Department of Veterans Affairs
Decentralized Hospital Computer Program

Includes Patches:

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INTEGRATED BILLING

USER MANUAL

Version 2.0

March 1994

Information Systems Center
Albany, New York

Preface

This is the user manual for the Integrated Billing (IB) software package. It contains documentation for all the IB software except the Encounter Form functionality. Documentation for Encounter Form options can be found in the IB User Manual, Encounter Form Utilities Module.

This manual is designed to provide guidance to a broad range of users within VA medical facilities in daily usage of the Integrated Billing software.

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Section 1 - Billing Clerk's Menu, cont.

Section 2 - Claims Tracking Master Menu, cont.

Section 4 - Billing Supervisor Menu, cont.

Table of Contents

Introduction

The release of Integrated Billing (IB) version 2.0 introduces fundamental changes to the way MCCR-related tasks are done. This software introduces three new modules; Claims Tracking, Encounter Form Utilities, and Insurance Data Capture.

There are also significant enhancements to the two previous modules, Patient Billing and Third Party Billing. IB has moved from a package with the singular purpose of identifying billable episodes of care and creating bills, to a package responsible for the whole billing process through to the passing of charges to Accounts Receivable (AR). Functionality has been added to assist in capturing patient data, tracking potentially billable episodes of care, completing utilization review (UR) tasks, and capturing more complete insurance information.

This version of IB has been targeted for a much wider audience than previous versions.

- The Encounter Form Utilities module is used by MAS ADPACs or clinic supervisors to create and print clinic-specific forms. Physicians use the forms and consequently provide input into their creation.

- The Claims Tracking module is used by UR nurses within MCCR and Quality Management (QM) to track episodes of care, do pre-certifications, do continued stay reviews, and complete other UR tasks.

- Insurance verifiers use the Insurance Data Capture module to collect and store patient and insurance carrier-specific data.

- The billing clerks see substantial changes to their jobs with the enhancements provided in the Patient Billing and Third Party Billing modules.

Following is an overview of the major functions of the Integrated Billing software, excluding the Encounter Form functionality. That information can be found in the IB User Manual, Encounter Form Utilities Module.

Patient Billing

- automates billing of pharmacy, inpatient, nursing home care unit (NHCU), and outpatient copayments; inpatient and NHCU per diem charges; and passing charges to Accounts Receivable (AR).

- automatically exempts patients who are eligible for VA Pension, Aid and Attendance, or House Bound benefits from the Medication Copayment requirement.

- provides for manual assignment of hardship exemptions from the copayment requirement and the ability to track those exemptions.

- integrates with the check-out functionality released in the PIMS V. 5.3 package. Patients who claim exposure to Agent Orange and environmental contaminants, and who are treated for conditions not related to this exposure, are billed automatically.

- allows patient charges to be added, edited, or deleted if there is no automated charge or the automated charge is incorrect.

- creates subsistence charges for CHAMPVA patients and passes to Accounts Receivable. This functionality will not be activated until the AR package releases a patch that allows AR to process CHAMPVA receivables.

- allows Means Test billing data to be transmitted between facilities in conjunction with PDX V. 1.5.

- automatically creates Means Test charges when a verified Means Test is electronically received from the Income Verification Match (IVM) Center.

Third Party Billing

- automates the creation of third party billing forms (UB-82, UB-92, HCFA-1500), allowing for the entry, editing, authorizing, printing, and canceling of bills.

- provides the ability to add prescription refills and prosthetic items to bills.

- expands the UB-92 functionality to include ability to add/edit all unlabeled form locators (except 49), additional diagnosis, some occurrence spans, and value codes.

- provides a check-off sheet (can be replaced by the Encounter Form depending on local needs) that can be printed in a variety of site configurable formats to be used in clinics to identify CPT codes.

- allows the transfer of CPT codes between the billing screens and the SCHEDULING VISITS file.

- provides reports to identify billable episodes of care, patient and insurance inquiries, and statistical data.

- provides the ability to create CHAMPVA bills. You will not be able to pass them to Accounts Receivable until the AR package releases a patch that allows AR to process CHAMPVA receivables.

- provides an employer report which lists uninsured patients who are employed.

- allows printing of all authorized bills in user-specified order.

- provides an Automated Biller which will automatically generate reimbursable insurance bills for inpatient stays, outpatient visits, and prescription refills. Through the use of site parameters, sites can specify what type of events are billed using the Automated Biller.

- provides an expanded HCFA-1500 claim form to include inpatient bills, user-specified charges, and multiple pages.

- provides an addendum sheet to HCFA-1500 claim form to list the bill's prescription refills and prosthetic items.

Insurance Data Capture

- stores multiple addresses (main mailing, outpatient claims, inpatient claims, prescription claims, appeals, inquiries) for each insurance carrier.

- provides insurance company-specific billing parameters so bills can reflect local insurance company requirements.

- provides the ability to establish group plans which will be pointed to by each patient with a policy attached to the plan. This saves re-entry of the same policy data for each patient.

- stores annual benefits associated with group plans.

- provides tools to maintain and/or clean up the INSURANCE COMPANY file.

- allows patient insurance information to be updated and verified.

- stores benefits used by a patient, such as deductibles and lifetime maximums.

- provides an insurance worksheet for use by the insurance verifier.

Claims Tracking

- provides the ability to track billing information concerning inpatient visits, outpatient visits, prescription refills, prosthetics, and fee basis visits from time of event until payment.
- provides a pending review (to do) list.
- introduces an Admission Sheet which can be placed in the front of the inpatient chart and used to document concurrent reviews.
- provides the feeding mechanism for automated bill preparation of third party bills.
- provides tracking of those cases requiring utilization review by VA Central Office (VACO) Quality Management (QM) office based on Interqual criteria.
- provides tracking of those cases where the insurance company requires reviews.
- provides tracking of appeals and denials.
- provides U/R management reports.

Additional Functionality

- purges data from selected IB files.
- provides the medical centers flexibility in implementing the package functionality through site parameters.
- provides the ability to enter new billing rates and VA pension income thresholds.
- produces management reports to provide workload, productivity, statistical, and historical data.

Related materials include the IB User Manual, Encounter Form Utilities Module; IB Technical Manual; Package Security Guide; Installation Guide; and Release Notes. The Technical Manual assists the site manager in maintenance of the software. The Package Security Guide provides information concerning security requirements for the package. The Installation Guide provides assistance in installation of the package while the Release Notes describe modifications and enhancements to the software that are new to this version.

Orientation

How To Use This Manual

This manual is divided into sections. Pages are numbered consecutively within each section in the format: section # - page #. Page 1 of Section 1 is "1-1", page 1 of Section 2 is "2-1", etc.

Each menu section begins with an overview of the options contained in it, followed by the actual option documentation. Most option documentation will contain the following components.

Introduction	The introduction gives a detailed description of the option and what it is used for. It will contain any special instructions related to the option.
Process Chart	The process chart illustrates the flow of the option step-by-step, giving the various choices and subsequent progression at each step.
Example	The example displays what you might see on the screen when using the option. A sample of any hard copy reports, MailMan messages, etc. generated by the option are usually included here.

The Process Charts will not contain documentation of the system's responses to erroneous input. In certain instances, in order to preserve the integrity of previously entered data, the system will not allow the entry of an up-arrow. This also may not be documented.

All user responses in this manual are shown in boldface type. The symbol <RET> is used to show when you are to press the Return or Enter key as your response to the prompt. The symbol <^> is used when referring to the up-arrow (caret).

Many options/menus in the IB package appear in more than one place on the menu structure. Generally, the documentation for a specific menu/option will only be provided in one section of the manual. You can refer to the Index of this user manual for the location of any specific option/menu documentation.

The following icons are used to highlight key points in the option documentation.

 Required security keys

 Enhancements and functionality changes

Package Management

Data in the INTEGRATED BILLING ACTION file should not be added to, edited, or deleted. This data is designed to provide an audit trail of transactions. If the charges for a copayment are removed, a separate transaction that is a cancellation type will be created and cause the decrease adjustment to be made. If charges are to be changed, the original (or last) charges are cancelled and the new charges are set-up as an update type transaction. Data in this file is maintained through documented routine calls from the Outpatient Pharmacy and MAS packages to Integrated Billing. Data in other Integrated Billing files should be maintained through package options.

Instructions to enter new billing rates and VA pension income thresholds will be provided by VACO and/or the Albany ISC.

The automated billing of Category C veterans for outpatient copayments, inpatient copayments, and per diems happens automatically through links to the scheduling event driver, the MAS movement event driver, and the nightly background job.

There are numerous parameters in the IB SITE PARAMETERS file that affect the functional and technical operations of the billing software.

There are several options that contain parameters that affect the operation of the IB package. The MCCR Site Parameter Enter/Edit option parameters affect the operation of the Patient and Third Party Billing modules. The Select Default Device for Forms option affects where forms will print. The Claims Tracking Parameter Edit option affects the operation of the Claims Tracking module. The Enter/Edit Automated Billing Parameters option allows the site to determine when and what bills are generated by the Automated Biller. The Enter/Edit IB Site Parameters option on the System Manager's IB Menu affects many of the technical aspects of the IB package.

Per VHA Directive 10-93-142, many of the IB routines, data dictionaries, and data files are not to be modified. Only the routines for Encounter Form utilities and selected outputs may be modified.

An electronic signature code is required for users of the Manually Change Copay Exemption (Hardships) option under the Medication Copayment Income Exemption Menu and the Purge Update File and Archive Billing Data options under the Purge Menu.

Package Operation

On-line Help

When the format of a response is specific, a Help message is usually provided for that prompt. Help messages provide lists of acceptable responses or format requirements which provide instruction on how to respond.

A Help message can be requested by typing one or two question marks. The Help message will appear under the prompt, then the prompt will be repeated. For example, perhaps you see the prompt

```
BILLING LOCATION OF CARE: 1//
```

and you need assistance answering. You enter ?? and the Help message would appear.

```
BILLING LOCATION OF CARE: 1// ??

This identifies the type of facility at which care was administered.
  Choose from:
    1        HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
    2        SKILLED NURSING (NHCU)
    3        CLINIC (WHEN INDEPENDENT OR SATELLITE)

BILLING LOCATION OF CARE: 1//
```

For some prompts, the system will list the possible answers from which you can choose. Any time choices appear with numbers, the system will usually accept the number or the name.

A Help message may not be available for every prompt. If you enter question marks at a prompt that does not have a Help message, the system will repeat the prompt.

Note to Users With "QUME" Terminals

It is very important that you set up your Qume terminal properly. After entering your access and verify codes, you will see the following prompt.

```
Select TERMINAL TYPE NAME: {type}//
```

Please make sure that C-QUME is entered here. This entry will become the default and you can then enter <RET> for all subsequent log-ins. If any other terminal type configuration is set, options using the List Manager utilities will not display nor function properly on your terminal.

SECTION 1- BILLING CLERK'S MENU

Claims Tracking Menu for Billing
Enter/Edit Billing Information
Automated Means Test Billing Menu
CHAMPUS Billing Menu
Patient Billing Reports Menu
Third Party Joint Inquiry
Third Party Billing Menu

Option Overview

ENTER/EDIT BILLING INFORMATION - Used to enter the information required to generate a third party bill and to edit existing billing information.

AUTOMATED MEANS TEST BILLING MENU

CANCEL/EDIT/ADD PATIENT CHARGES - Allows you to manually cancel, edit or add per diem and copayment patient charges or fee services for a specified patient and date range.

PATIENT BILLING CLOCK MAINTENANCE - Allows adding or editing of patient billing clocks.

ESTIMATE CATEGORY C CHARGES FOR AN ADMISSION - Used to estimate the Means Test/Category C charges for an episode of hospital or nursing home care for a proposed length of stay.

ADD/EDIT PTS. CONTINUOUSLY HOSPITALIZED SINCE 1986 - Allows you to add or edit entries in the CONTINUOUS PATIENT file (#351.1) for patients continuously hospitalized at the same level of care since 1986.

ON HOLD MENU

HELD CHARGES REPORT - Provides a list of all charges with a status of ON HOLD. Charges for Category C patients with insurance are placed ON HOLD until the patient's insurance company bill is resolved.

RELEASE CHARGES 'ON HOLD' - Used to release Means Test Category C charges, with a status of ON HOLD, to Accounts Receivable.

LIST CHARGES AWAITING NEW COPAY RATE - Used to generate a list of all Means Test outpatient copayment charges which have been placed on hold because the copay rate is over one year old.

SEND CONVERTED CHARGES TO A/R - Designed for use after the Integrated Billing conversion is completed. After the conversion, certain inpatient and outpatient charges will have a status of CONVERTED. This option allows you to choose which converted charges are passed to Accounts Receivable.

RELEASE CHARGES 'PENDING REVIEW' - Used to release charges which have been created as a result of an Income Verification Match (IVM) verified Means Test being received and filed at the medical facility.

RELEASE CHARGES AWAITING NEW COPAY RATE - Used to release charges which have been placed on hold because the outpatient copay rate is over one year old.

PATIENT BILLING CLOCK INQUIRY - Allows you to display data contained in the patient billing clock.

CATEGORY C BILLING ACTIVITY LIST - Used to list all Means Test/Category C charges within a specified date range.

SINGLE PATIENT CATEGORY C BILLING PROFILE - Provides a list of all Means Test/Category C charges within a specified date range for a selected patient.

DISPOSITION SPECIAL INPATIENT BILLING CASES - Used to enter the reason for not billing inpatient billing cases for veterans whose care is related to their exposure to Agent Orange, ionizing radiation, or environmental contaminants.

LIST SPECIAL INPATIENT BILLING CASES - Used to provide a listing of all special inpatient billing cases, both dispositioned and undispositioned.

CHAMPUS BILLING MENU

DELETE REJECT ENTRY - Allows you to delete individual entries from the CHAMPUS PHARMACY REJECTS (#351.52) file.

REJECT REPORT - Allows you to view all of the entries in the CHAMPUS PHARMACY REJECTS (#351.52) file and determine the reason(s) for the rejected entries.

RESUBMIT A CLAIM - Used to resubmit a transaction which was originally rejected by the FI (Fiscal Intermediary - the company with which a Tricare patient holds their Tricare insurance coverage).

REVERSE A CLAIM - Used to reverse or cancel a claim for a prescription that was submitted in error.

TRANSMISSION REPORT - Allows you to view a list of pharmacy transmissions for prescriptions which were filled during a specified date range.

PATIENT BILLING REPORTS MENU

PRINT CHECK-OFF SHEET FOR APPOINTMENTS - Allows you to print Ambulatory Surgery Check-Off Sheets by patient name or clinic for a specified appointment date.

PATIENT CURRENTLY CONT. HOSPITALIZED SINCE 1986 - Allows you to print a list (from the IB CONTINUOUS PATIENT file) of current inpatients continuously hospitalized at the same level of care since 1986.

PRINT IB ACTIONS BY DATE - Provides a list of the Integrated Billing actions for a specified date range.

EMPLOYER REPORT - Provides a listing of veteran's employers which may be used to confirm insurance coverage with those employers.

EPISODE OF CARE BILL LIST - Used to list all bills related to an episode of care.

ESTIMATE CATEGORY C CHARGES FOR AN ADMISSION - Used to estimate the Means Test/Category C charges for an episode of hospital or nursing home care for a proposed length of stay.

OUTPATIENT/REGISTRATION EVENTS REPORT - Designed to show potentially billable outpatient activity (i.e., scheduled appointments, add/edits, and registrations) and related billing activity for a date range.

HELD CHARGES REPORT - Provides a list of all charges with a status of ON HOLD.

PATIENT BILLING INQUIRY - Allows you to display/print information on any reimbursable insurance bill, pharmacy copay, or Means Test bill.

LIST ALL BILLS FOR A PATIENT - Used to print a list of all bills on file for a selected patient.

CATEGORY C BILLING ACTIVITY LIST - Used to list all Means Test/Category C charges within a specified date range.

THIRD PARTY OUTPUT MENU

VETERANS W/INSURANCE AND DISCHARGES - Used to produce a list of all patients who have reimbursable insurance and who were discharged from the medical center during a selected date range.

VETERAN PATIENT INSURANCE INFORMATION - Provides insurance information on veteran inpatients.

VETERANS W/INSURANCE AND INPATIENT ADMISSIONS - Used to produce a list of all patients who have reimbursable insurance and who had admissions to the medical center during a selected date range.

VETERANS W/INSURANCE AND OPT. VISITS - Used to produce a list of all patients who have reimbursable insurance and who had outpatient visits to the medical center during a selected date range.

PATIENT REVIEW DOCUMENT - Used to print the Third Party Review Form by patient name and admission date specifications.

INPATIENTS W/UNKNOWN OR EXPIRED INSURANCE - Allows you to print a list of veteran inpatients with no insurance, expiring insurance (expired or will expire within 30 days), or unknown insurance.

OUTPATIENTS W/UNKNOWN OR EXPIRED INSURANCE - Allows you to print a list of veteran outpatients with no insurance, expiring insurance (expired or will expire within 30 days), or unknown insurance for a specified date range.

SINGLE PATIENT CATEGORY C BILLING PROFILE - Provides a list of all Means Test/Category C charges within a specified date range for a selected patient.

CHECK OFF SHEET PRINT - Allows you to print Ambulatory Surgery Check-Off Sheets that have been set up through the Build CPT Check-off Sheet option.

THIRD PARTY JOINT INQUIRY - Provides information needed to answer questions from insurance carriers regarding specific bills or episodes of care.

THIRD PARTY BILLING MENU

PRINT BILL ADDENDUM SHEET - Used to print the addendum sheets that may accompany HCFA 1500 RX refill or prosthetic bills. The addendum contains information that could not fit on the bill form.

AUTHORIZE BILL GENERATION - Used to authorize the printing of third party bills and the release of the information to Fiscal Service.

ENTER/EDIT BILLING INFORMATION - Used to enter the information required to generate a third party bill and to edit existing billing information.

CANCEL BILL - Allows the user to cancel a bill at any point in the billing process.

COPY AND CANCEL - Used to cancel a bill, copy all the information into a new bill, and edit the new bill where necessary.

DELETE AUTO BILLER RESULTS - Used to delete entries from the Automated Biller Errors/Comments report prior to a user-selected date for any entry not associated with a bill.

PRINT BILL - Used to print third party bills on the appropriate form (UB-82, UB-92, or HCFA-1500) after all required information has been input and the billing record has been authorized.

PATIENT BILLING INQUIRY - Allows you to display/print information on any reimbursable insurance bill, pharmacy copay, or Means Test bill.

PRINT AUTO BILLER RESULTS - Used to print the Automated Biller Errors/Comments report.

PRINT AUTHORIZED BILLS - Print all authorized bills by user-specified order.

RETURN BILL MENU

> EDIT RETURNED BILL - Used to correct bills with a status of RETURNED FROM AR (NEW) which have been returned to MAS from Accounts Receivable.
>
> RETURNED BILL LIST - Prints a listing of all bills that have been returned to MAS from Accounts Receivable.
>
> RETURN BILL TO A/R - Used to send bills which have been returned to MAS back to Accounts Receivable after they have been corrected.

UB-82 TEST PATTERN PRINT - Used to print a test pattern on the UB-82 billing form so that the form alignment in the printer can be checked.

UB-92 TEST PATTERN PRINT - Used to print a test pattern on the UB-92 billing form so that the form alignment in the printer can be checked.

HCFA-1500 TEST PATTERN PRINT - Allows you to print a test pattern on the HCFA-1500 form in order for the form alignment in the printer to be checked.

OUTPATIENT VISIT DATE INQUIRY - Allows you to display information on any outpatient insurance bill for a selected patient.

Enter/Edit Billing Information

When entering a patient name at the first prompt, a list of the patient's bills is provided. This list has been updated to include the types of charges on each bill: inpatient (institutional/ professional), opt visit date, prescription, CPT, and/or prosthetic.

When creating a new bill, a list of the bills for the patient that have the same event date as the new bill is provided. This list has been updated to include the types of charges on each bill: inpatient (institutional/professional), opt visit date, prescription, CPT, and/or prosthetic.

New help has been added to display the HCFA 1500 block 24. Enter "?HCFA" and a replica of how the claim will print on the HCFA 1500 block 24 will be displayed.

The automatic addition of charges to a bill has been updated to use the Charge Master rather than the old rates in the BILLING RATES file (#399.5).

A new edit check has been added when editing of the bill is complete. This edit check will provide a warning if the Patient Short Address on a UB-92 bill has been left blank. This is a warning only. This field is not required, so the bill may still be authorized.

If entering an inpatient bill, a non-covered amount (UB-92 form locator 48) can be entered for each revenue code you enter. This was requested as a way to report pass days and is an optional data element.

Screen 3

Form Type must now be a national/print form to be valid. You cannot enter a local form name here. (This field is only used to determine the general format of the bill, not what form prints).

If the bill has indicated secondary insurance, Primary Prior Payment data can be entered. If the bill has indicated tertiary insurance, Primary and Secondary Prior Payment data can be entered. (form locators 54a,b on the UB-92).

Enter/Edit Billing Information

On bills that have only Rx charges, the Prescription mailing address of the Primary Insurance Company will be used as the bill's mailing address. If the Insurance Company does not have a specific address for Rxs, then the Outpatient Mailing Address will be used.

Screens 4 and 5

When entering procedures, the DIVISION will only be asked if there may be CPT charges for the bill that are identified by region/locality of care. This is true if the procedures are being added manually or from Scheduling.

If there may be CPT based charges for the bill, then the bill's charges will be automatically recalculated if any CPTs are added/edited.

When adding prescriptions to the bill, if there is a site, DEFAULT RX REFILL CPT (#350.9,1.3); or a site, DEFAULT RX REFILL DX (#350.9,1.29), defined then they are automatically added to the bill. This has been updated so that if both of these exist, then the DEFAULT RX REFILL DX will be added as the ASSOCIATED DIAGNOSIS (1) (#399,304,10) for the site DEFAULT RX REFILL CPT.

The original prescription fill and all refills will be displayed for both types of CHAMPUS bills.

A new prompt, "CPT Modifier" appears when entering procedure information if the Procedure Coding Method entered is CPT-4.

Screen 6

When entering revenue code charges for inpatients, you can now enter a non-covered charge.

Screens 6 and 7

The first data set (option 1) has been updated with a new field, DEFAULT DIVISION. This field is Not Required. It will be used to determine if the bill falls within a particular Billing Region.

A new selection has been added, [6] Rate Schedule, to allow you to force a bills charges to be recalculated and to allow you to choose which charges to add to a bill. This will display all Rate Schedules and Charge Sets that have been assigned to the Rate Type and Bill Classification (Inpt/Opt) of the bill.

Enter/Edit Billing Information

When manually entering charges and revenue codes two new fields will be asked: TYPE and COMPONENT.

When entering charges and revenue codes, PROCEDURE will always be asked. This was only asked if the bill was a HCFA 1500.

When entering charges and revenue codes, the DIVISION will only be asked if there may be CPT charges based on location of care for the bill, and if a PROCEDURE has been entered.

Screen 9
New local screen, if defined for form type of bill (UB-92 or HCFA 1500).

 IB EDIT security key required to access this option.

Introduction

The Enter/Edit Billing Information option is used to enter the information required to generate a third party bill and to edit existing billing information. A new bill can be entered or an existing bill can be edited, as long as the existing bill has not been authorized or cancelled. Once a bill has been filed (billing record number established), it cannot be deleted. The bill can be cancelled through the Cancel Bill option.

If the selected patient's eligibility has not been verified and the ASK HINQ IN MCCR parameter is set to YES, the user will have the opportunity to enter a HINQ (Hospital Inquiry) request into the HINQ Suspense File. This request will be transmitted to the Veterans Benefits Administration to obtain the patient's eligibility information. If Means Test data such as category, Means Test last applied, and date Means Test completed is available, it will be displayed after the patient name or bill number has been entered.

When entering a new bill, the system will prompt for EVENT DATE. When billing for multiple outpatient visits, the date of the initial visit is used. For an inpatient bill, the date of the admission is used. If an interim bill is being issued, the EVENT DATE should be the date of admission for that episode of care.

Introduction, cont.

The Medical Care Cost Recovery data is arranged so that it can be viewed and edited through various screens. The data is grouped into sections for editing. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by brackets ([ ]) can be edited while those enclosed by arrows (< >) cannot. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient) and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the data groups found on that screen and also provides the name and number of each available screen in the option.

SCREEN 1 - DEMOGRAPHIC INFORMATION
The Demographic Screen contains patient information such as date of birth, marital status, address, phone number (although the phone number is not displayed, it is included in Group 5) and whether or not the patient was service connected for any condition at the time the care on the bill was rendered. Much of this screen is automatically filled in from data in the PATIENT file. Users who do not hold the DG ELIGIBILITY security key will only be able to edit the alias, address, and patient short address prompts. The Patient Short Address prompt is for a shortened version of the patient's address if over 47 characters (to fit on the billing form).

SCREEN 2 - EMPLOYMENT INFORMATION
The Employment Screen lists the patient's employer, employer address, and his/her employment status. The spouse's employer may also be listed. Spouse's employment data will only be editable if the patient is married or separated.

SCREEN 3 - PAYER INFORMATION
Screen 3 contains information regarding rate type and who is responsible for payment of the bill; patient, insurer, or other. OTHER status may include another VA, a private hospital, etc. You can make a new entry to the INSTITUTION file from this screen.

The bill mailing address appears on this screen. Please see the Data Supplement at the end of this option documentation for important information on how this is determined.

Introduction, cont.

When insurance companies are entered into the INSURANCE COMPANY file, the system prompts for whether or not this company will reimburse VA for the cost of the patient's care. Entry of an insurance company that has been designated as "will not reimburse" is not allowed at this screen. For bills where the payer is the insurance company and the patient has one insurance company that will reimburse the government, that company will be stored as the primary insurance company. Inactivating the insurance company has no effect on the insurance carriers associated with the bill.

Selection of insurance companies is limited to the primary, secondary, and tertiary insurance companies that are billable for the event date. A provider number can be entered for each of the three possible insurance carriers. This field will be loaded from the Hospital Provider Number if one has been entered for the insurance carrier.

Insurance company addresses can only be edited through the Insurance Company Entry/Edit option.

Any bill with a CHAMPVA rate type requires the primary insurance carrier to have a type of coverage defined as CHAMPVA; otherwise, the bill cannot be authorized.

If the MULTIPLE FORM TYPES site parameter is set to YES, a form type prompt will appear. The UB-82 and UB-92 are considered a single form, so for a site to have multiple forms they would have to use one of the UB forms and the HCFA-1500.

Changing the form type to HCFA-1500 will cause the CODING METHOD field to default to CPT-4 if it has not already been defined. Changing the primary insurance carrier or responsible institution will cause the revenue codes to be rebuilt and charges to be recalculated.

SCREEN 4 - EVENT INPATIENT INFORMATION

Screen 4 appears for inpatient bills only. This screen includes data concerning admission and discharge dates, principal diagnosis and procedures, prosthetics, and for accidents, the time the accident occurred. If the MCCR site parameter CAN CLERK ENTER NON-PTF CODES? is set to YES, diagnosis and procedure codes not found in the PTF record can be input into the billing record. Occurrence, condition, and value codes also appear on this screen.

Introduction, cont.

A print order can be specified for each procedure/diagnosis entered. If no print order is specified, the procedures/diagnoses will print in the order entered. The six procedures and nine diagnoses with the lowest print order will be printed in the boxes on the form and the remainder will print as additional procedures/diagnoses.

SCREEN 5 - EVENT OUTPATIENT
Screen 5 appears for outpatient bills only. This screen displays data concerning the diagnosis, coding method, and outpatient procedure codes. The coding method must be specified before outpatient procedure codes can be entered/edited. Diagnosis coding is possible on this screen. Information concerning prosthetics and prescription refills is located here. The RX original fill date for bills with a rate type of CHAMPVA will now be displayed (if within the bill's date range.) Occurrence, condition, and value codes also appear on this screen.

If the MCCR site parameter USE OP CPT SCREEN is set to YES, the Current Procedural Terminology Code Screen will appear when editing procedure codes. The screen will list CPT codes for the dates associated with the bill.

An associated diagnosis (diagnosis responsible for the procedure being performed) must be entered for each procedure for HCFA-1500s. You can enter from 1 to 4 associated diagnoses. The associated diagnosis must match one of the first four diagnoses entered.

Adding a BASC procedure or an OP VISIT DATE will cause the revenue codes to be rebuilt and charges recalculated for both UB-82/92 and HCFA-1500 form types. Only one visit date is allowed on a UB-82/92 that also has BASC procedures. This restriction does not apply to HCFA-1500s.

A print order can be specified for each procedure/diagnosis entered. If no print order is specified, the procedures/diagnoses will print in the order entered. The six procedures and nine diagnoses with the lowest print order will be printed in the boxes on the form and the remainder will print as additional procedures/diagnoses.

If the TRANSFER PROCEDURES TO SCHED? parameter is set to YES, any ambulatory surgery entered on the bill can be transferred to the Scheduling Visits file and stored under a 900 stop code. An associated clinic must be entered for all procedures that are to be transferred to the SCHEDULING VISITS file.

Introduction, cont.

SCREEN 6 & 7 - BILLING GENERAL INFORMATION
The Billing Screen appears differently for inpatient (Screen 6) and outpatient (Screen 7) episodes. Both screens include bill from and to dates, charges, bill type, time frame, covered and non-covered days, and assignment of benefits. If the billing period crosses fiscal or calendar years, two separate bills must be prepared (one for each fiscal/calendar year). Adding an OP VISIT DATE or entering the STATEMENT FROM and STATEMENT TO dates will cause the revenue codes to be rebuilt and charges to be recalculated for both UB-82/92 and HCFA-1500 forms.

Screen 6 also contains the discharge bedsection and length of stay (in days). The automatic length of stay calculation excludes the date of discharge. For interim first and interim continuous bills, each day is added to the length of stay so interim bills do not overlap. Screen 7 allows for input of outpatient visit dates, up to 30 visits per bill. Only one visit date is allowed on UB-82/92s that also have BASC procedures. This restriction does not apply to HCFA-1500s.

Revenue codes and rates are automatically calculated. You can add additional revenue codes. Each revenue code will be associated with a bedsection. To itemize a CHAMPVA outpatient bill, a CPT procedure code may be added to each revenue code on Screen 7.

When editing a sensitive record, (one which contains information pertaining to drugs, alcohol, sickle cell anemia, or other sensitive information), the user will be prompted for R.O.I. form. This field denotes whether or not release of information forms have been signed.

When entering an offset amount (amount to be subtracted from the total charges on the bill; i.e., copayment, deductible), entry of an offset description can also be entered.

When entering a third party bill (anything not billed to the patient), the ASSIGNMENT OF BENEFITS field will automatically be set to YES and cannot be edited.

Introduction, cont.

SCREEN 8 - BILLING SPECIFIC INFORMATION
For UB-92 forms, this screen contains the bill remark, treatment authorization code, admitting diagnosis, attending and other physicians, and those locators on the billing form which are unlabeled (locator 49 is uneditable). The UB-82 form excludes specific fields for the admitting diagnosis and the physicians; however, they can be entered into the unlabeled form locators. For HCFA-1500 forms, this screen contains the unable to work from and to dates, Block 31 entry/edit, and treatment authorization code.

Several site parameters and two security keys affect the prompts which appear at the end of this option. Please see the Data Supplement at the end of this option documentation for an explanation of how these site parameters and security keys affect the option.

A mail group can be specified (through the site parameters) so that every time a bill is disapproved during the authorization phase of the billing process, all members of this group are notified via electronic mail. If this group is not specified, only the billing supervisor, the initiator of the billing record, and the user who disapproved the bill will be recipients of the message. An example of this message can be found in the Data Supplement.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which can be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

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Enter/Edit Billing Information

Example 1 - Inpatient Bill

```
Enter BILL NUMBER or PATIENT NAME: JACKSON,SALLY         02-09-60     208442336
YES     SC VETERAN

                          *** WARNING ***
                     *** RESTRICTED RECORD ***
                *** ELIGIBILITY NOT VERIFIED ***

Patient Requires a Means Test
Primary Means Test Required from ''

  1   OCT 4,1996         K700020  REIM INS-Opt              ENTERED
  2   OCT 3,1996         K700019  REIM INS-Opt              ENTERED
  3   OCT 1,1996         K700016  REIM INS-Inpt             ENTERED
  4   OCT 1,1996         K700017  REIM INS-Opt              ENTERED
  5   OCT 1,1996         K700018  REIM INS-Opt              ENTERED

PRESS <RETURN> TO CONTINUE, OR
CHOOSE 1-5: ^

DO YOU WANT TO ESTABLISH A NEW BILLING RECORD FOR ' JACKSON,SALLY '? No// y  (Yes)
   BILLING LOCATION OF CARE: 1// 1  HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
BILLING BILL CLASSIFICATION: 1  INPATIENT (MEDICARE PART A)
   BILLING TIMEFRAME OF BILL: 1  ADMIT THRU DISCHARGE CLAIM
   BILLING IS THIS A SENSITIVE RECORD?: NO// NO  (NO)
   BILLING RATE TYPE:  reiMBURSABLE INS.       Who's Responsible: INSURER
    Select INPATIENT EVENT (ADMISSION) DATE:
        1   JAN 23,1996@16:18:06        2   AUG 22,1994@13:09:55
        3   AUG 16,1994@13:00           4   APR 2,1994@15:00
        5   MAR 31,1994@12:00           6   JAN 21,1994@19:42:24
        7   JAN 13,1994@22:22:30        8   NOV 15,1993@13:03:01
        9   MAR 3,1993@13:00            10   JUL 5,1990@10:38
    OR
    Select NON-VA INPATIENT EVENT (ADMISSION) DATE:
        11   DEC 17,1991                12   JUL 9,1994@09:00
        13   JUL 25,1994                14   AUG 14,1994

    CHOOSE 1-14 or Enter DATE:  1
    PTF record indicates 0 of 1 movements are for Service Connected Care.

  Insurance Co.     Subscriber ID     Group       Holder  Effectve Expires  Only
  ================================================================================
  NEW HEALTH        9999              Ind. Plan   SPOUSE  08/04/93 05/31/94
  BC/BS OF ALBANY   208442336                     SELF    07/01/94
  ABC               SI333             HJKJ        SELF    11/12/94
```

Example 1 - Inpatient Bill, cont.

```
JACKSON,SALLY   208-44-2336   BILL#: K700059 - Inpatient            SCREEN <6>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 111                Timeframe: ADMIT THRU DISCHARGE
    Covered Days: UNSPECIFIED Non-Covered Days: UNSPECIFIED
    Division    :
[2] Sensitive?  : NO                Assignment: YES
[3] Bill From   : JAN 23, 1996         Bill To: SEP 30, 1996
[4] Bedsection  : UNSPECIFIED
    LOS         : 251
[5] Rev. Code   : 101-ALL INCL R&B              $150,098.00  GENERAL MEDICAL
    Rev. Code   : 240-ALL INCL ANCIL             $63,252.00  GENERAL MEDICAL
    Rev. Code   : 960-PRO FEE                    $29,116.00  GENERAL MEDICAL
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  : $242,466.00
    FY 1        : 96                    Charges: $242,466.00
[6] Rate Sched  : (re-calculate charges)


<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT: 1
TIMEFRAME OF BILL: ADMIT THRU DISCHARGE CLAIM// <RET>
COVERED DAYS: 8
NON-COVERED DAYS: 1
DEFAULT DIVISION: <RET>

JACKSON,SALLY   208-44-2336   BILL#: K700059 - Inpatient            SCREEN <6>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 111                Timeframe: ADMIT THRU DISCHARGE
    Covered Days: 8           Non-Covered Days: 1
    Division    :
[2] Sensitive?  : NO                Assignment: YES
[3] Bill From   : JAN 23, 1996         Bill To: SEP 30, 1996
[4] Bedsection  : UNSPECIFIED
    LOS         : 251
[5] Rev. Code   : 101-ALL INCL R&B              $150,098.00  GENERAL MEDICAL
    Rev. Code   : 240-ALL INCL ANCIL             $63,252.00  GENERAL MEDICAL
    Rev. Code   : 960-PRO FEE                    $29,116.00  GENERAL MEDICAL
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  : $242,466.00
    FY 1        : 96                    Charges: $242,466.00
[6] Rate Sched  : (re-calculate charges)


<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>
```

Example 2 - Outpatient Bill

```
Enter BILL NUMBER or PATIENT NAME:    K700018       JACKSON,SALLY     10-01-96
    Outpatient     REIMBURSABLE INS.     ENTERED/NOT REVIEWED
                *** ELIGIBILITY NOT VERIFIED ***

Patient Requires a Means Test
Primary Means Test Required from ''


JACKSON,SALLY   208-44-2336   BILL#: K700018 - Outpatient           SCREEN <1>
================================================================================
                             DEMOGRAPHIC INFORMATION
[1] DOB    : FEB 9,1960
[2] Alias  : NO ALIAS ON FILE
[3] Sex    : FEMALE                    Marital: NEVER MARRIED
[4] Veteran: YES                   Eligibility: SC, LESS THAN 50%

[5] Address: 415 SUMMER STREET       Temporary: NO TEMPORARY ADDRESS
SUMMERVILLE, PA 15221

[6] Pt Short
    Address: 415 SUMMER STREET,APT #10,SUMMERVILLE,PA 15221

[7] SC Care: YES  (Enter '7' to list disabilities)



<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>


JACKSON,SALLY   208-44-2336   BILL#: K700018 - Outpatient           SCREEN <2>
================================================================================
                             EMPLOYMENT INFORMATION
[1] Employer: MACY'S           <2> Spouse's: UNSPECIFIED
              STREET ADDRESS UNKNOWN
              CITY/STATE UNKNOWN
       Phone: UNSPECIFIED
  Occupation: SALES PERSON
      Status: RETIRED



<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>
```

Example 2 - Outpatient Bill, cont.

```
JACKSON,SALLY    208-44-2336   BILL#: K700018 - Outpatient           SCREEN <5>
================================================================================
                          EVENT - OUTPATIENT INFORMATION
<1> Event Date : OCT 01, 1996
[2] Prin. Diag.: UNSPECIFIED [NOT REQUIRED]
[3] OP Visits  : OCT 1,1996, OCT 2,1996, OCT 4,1996,
[4] Cod. Method: UNSPECIFIED [NOT REQUIRED]
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[9] Value Code : UNSPECIFIED [NOT REQUIRED]


<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>


JACKSON,SALLY    208-44-2336   BILL#: K700018 - Outpatient           SCREEN <7>
================================================================================
                           BILLING - GENERAL INFORMATION
[1] Bill Type   : 131               Timeframe: ADMIT THRU DISCHARGE
    Covered Days: UNSPECIFIED          Division:
    Non-Cov Days: UNSPECIFIED        Disch Stat:
[2] Sensitive?  : NO               Assignment: YES
[3] Bill From   : OCT 01, 1996        Bill To: OCT 04, 1996
[4] OP Visits   : OCT 1,1996, OCT 2,1996, OCT 4,1996,
[5] Rev. Code   : 500-OUTPATIENT SVS              $582.00  OUTPATIENT VISIT
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :     $582.00
    FY 1        : 97                  Charges:     $582.00
[6] Rate Sched  : (re-calculate charges)


<RET> to CONTINUE, 1-5 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>

JACKSON,SALLY   208-44-2336   BILL#: K700018 - Outpatient           SCREEN <8>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[1] Bill Remark     : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code   : UNSPECIFIED [NOT REQUIRED]
    Admitting Dx    : UNSPECIFIED [NOT REQUIRED]
[2] Attending Phy.  : UNSPECIFIED [NOT REQUIRED]
    Other Physician : UNSPECIFIED [NOT REQUIRED]
[3] Form Locator 2  : UNSPECIFIED [NOT REQUIRED]
    Form Locator 11 : UNSPECIFIED [NOT REQUIRED]
[4] Form Locator 31 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 37 : UNSPECIFIED [NOT REQUIRED]
[5] Form Locator 56 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 57 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 78 : UNSPECIFIED [NOT REQUIRED]

<RET> to CONTINUE, 1-5 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>
```

Enter/Edit Billing Information

DATA SUPPLEMENT
This section is provided to give further clarification to the following elements which appear in the Enter/Edit Billing Information option.

Fields	Explanation of select fields (data items) found in this option.
Parameters and Security Keys	Explanation of select parameters and security keys which affect the functioning of this option.
Mail Messages	Example of electronic mail messages generated by this option.
Billing Mailing Address	Explanation of how the billing mailing address is determined.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
1	Patient Short Mailing Address	Abbreviated patient mailing address (if necessary). Address cannot exceed 47 characters for billing form.
1	SC at Time of Care	Was this patient service connected for any condition at the time the care in the bill was rendered. This field is used to correctly assign Accounts Receivable AMIS segments to this bill if it is a Reimbursable Insurance bill. The default for this field is the current value in the SC PATIENT field of the PATIENT file. If this field is left blank, the default value will be used to determine the AMIS segment.
3	Institution Name	When payer is "other", name of institution responsible for payment of bill (i.e., other VAMC, federal agency, private hospital).

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
3	Form Type	The type of form the bill is printed on. If the MULTIPLE FORM TYPES parameter is set to YES, this field will appear.
3	Primary/Secondary/ Tertiary Provider	The number assigned to the provider by the primary/secondary/tertiary payer.
4	Admission	Date of admission for inpatient bill (event date).
4	Source of Admission	Source of this patient admission; i.e., clinic referral.
4	Type of Admission	EMERGENCY - Used for emergency admissions. URGENT - Used for routine admissions. ELECTIVE - Cosmetic surgery, etc. (should not be used routinely).
4	Accident Hour	Time of accident or injury (to be used only with episodes of care resulting from an accident).
4	Discharge Status	Patient status at time of discharge; i.e., expired, left against medical advice.
4	Principal Diagnosis	Code of diagnosis responsible for patient's greatest length of stay for this inpatient hospital episode. Automatically filled in from PTF record, if available.
4	Principal Procedure	Principal surgery or procedure occurring during this inpatient hospital episode (if any). Automatically filled in from PTF record, if available.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
4	Procedure Coding Method	Coding method used for procedure/surgery coding. The choices are CPT-4, HCPCS, or ICD-9-CM.
4, 5	Occurrence Code	Event relating to bill that may affect insurance processing (if applicable). Some codes relate to a single date while others relate to a date range.
4, 5	Condition Code	Condition relating to patient that may affect insurance processing (if applicable).
4, 5	Value Code	This code relates amounts or values to identified data elements necessary to process the claim as qualified.
4, 5	Order	This is the print order in which the procedures/diagnoses will appear on the form. The six lowest procedure and nine lowest diagnosis numbers will appear on the form in the boxes, the rest will print as additional procedures/diagnoses. If no print order is specified, the procedures/diagnoses will print in the order entered.
4, 5	Place of Service	Used in Block 24C of the HCFA-1500 form indicating where the procedure was provided.
4, 5	Type of Service	Used in Block 24D of the HCFA-1500 billing form indicating what kind of medical care was provided for this procedure.
4, 5	State	If the treatment is related to an automobile accident, this field is used to specify the location on the HCFA-1500 form.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
5	Event Date	Outpatient bill (only one visit) - date of visit. Outpatient bill (multiple visits) - date of initial visit.
5	Associated Clinic	The clinic where the procedure was performed. This field must be completed for this procedure to be successfully transferred to the Add/Edit Stop code logic for inclusion in OPC workload.
5	Associated Diagnosis	This is the diagnosis for the procedure being performed. An associated diagnosis (up to 4) must be entered for each procedure when using the HCFA-1500 form. It must match one of the first four diagnoses entered.
5	Division	A division must be entered for all BASC procedures. This is required for the charge calculation.
5	Opt. Code	Code name/number for outpatient procedure/surgery performed. Bypass if no procedures/surgeries performed.
5, 7	OP Visits	Multiple field for outpatient bills. For facilities that bill more than one visit per bill, field where the facility can specify all the outpatient visit dates being billed (up to 30 per bill).
6	Discharge Bedsection	Patient's bedsection at time of discharge.
6	Length of Stay	Length of stay in days. Excludes the discharge date of all bills that are not interim first or interim continuous.

DATA SUPPLEMENT, cont.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
6, 7	Revenue Code	Code which identifies a specific accommodation, ancillary service, or billing calculation. Can enter up to 10 active codes per bill. You can add codes for a patient from the list provided, but cannot add new codes to the list.
6, 7	Charges	Cost of 1 unit of service; i.e., 1 inpatient day, 1 outpatient visit.
6, 7	Units of Service	Number of units of service rendered to this patient for a specific revenue code.
6, 7	Offset Amount	Dollar amount that is to be subtracted from the total charges on this bill; i.e., copayments, deductibles.
6, 7	Bill Total	Units of service (x) charges for all Revenue codes.
6, 7	Statement Covers From	Statement covers services rendered from this date. Use event date if billing from admission through discharge or if billing for opt. services. Use beginning date of services covered by bill for interim billing. Interim inpatient bills should no longer overlap.
6, 7	Statement Covers To	Statement covers services rendered to this date. Use discharge date if billing from admission through discharge. Use date of last opt. visit for outpatient bills. Use ending date of services covered by bill for interim bills. Interim inpatient bills should no longer overlap.
6, 7	R.O.I. Form(s) Completed	Release of Information form completed or not completed.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
6, 7	Assignment of Benefits	Will automatically be set to YES when entering a third party bill and will not be editable.
6, 7	Power of Attorney	Have Power of Attorney forms been signed? Will only appear if occurrence codes selected pertain to an accident.
6, 7	FY 1	Will be automatically set to fiscal year of event date and FY1 charges will equal bill total (offset not deducted).
6, 7	Procedure	Associates a particular revenue code charge with a specific CPT procedure on the HCFA-1500 form.
6, 7	Covered/Non-Covered Days	Number of days covered/not covered by the primary payer.
8	Bill Comment	Remarks associated with this bill which will print on the UB-82/92 form (2-35 characters).
8	Form Locator fields	Unlabeled fields on UB-82/92 form. Use may be determined at the state or national level after negotiations between payers and providers.
8	Treatment Authorization Code	Number or other indicator that designates that the treatment covered by this bill has been authorized by the payer.

PARAMETERS

1. CAN INITIATOR AUTHORIZE	If set to YES, user who entered bill can authorize generation of billing form (if required security keys held). If this parameter is set to NO, the person who entered the bill will not be allowed to authorize its generation.
2. CAN CLERK ENTER NON-PTF CODES	If set to YES, user will be allowed to enter diagnosis and procedure codes not found in the PTF record into the billing record. User will also be able to select ICD-9-CM, CPT-4, or HCPCS as the procedure coding method and can enter CPT or ICD procedure codes into the billing record, if desired. If this parameter is set to NO, the user will be able to enter into the billing record only those diagnosis and procedure codes found in the PTF record associated with the episode of care being billed.
3. DEFAULT RX REFILL REV CODE	If entered, this revenue code will be used for all prescription refills on a bill when the revenue codes and charges are automatically calculated. This default will be overridden by the PRESCRIPTION REFILL REV. CODE for an insurance company, if one exists.

PARAMETERS

4. TRANSFER PROCEDURES TO SCHED	CPT procedures can be stored as ambulatory procedures in the SCHEDULING VISITS file (using the Add/Edit Stop Code option), as well as in the billing record as procedures to print on a bill. There is now a two-way sharing of information between these two files. If this parameter is answered YES, as CPT procedures that are also ambulatory procedures are entered into a bill, the user will be prompted as to whether they should also be transferred to the SCHEDULING VISITS file. Conversely, through the USE OP CPT SCREEN? parameter you may allow importing of ambulatory procedures into a bill. Only CPT procedures that are Billable Ambulatory Surgical Codes, or either nationally or locally active ambulatory procedures can be transferred.
5. DEFAULT DIVISION	This field will be used as the default answer to the division question when entering billable ambulatory surgeries into a bill. Enter in this field the name of a division at your facility. It can be the main building, a satellite clinic, a domiciliary, or a nursing home.
6. MEDICARE PROVIDER NUMBER	The 1-8 character number provided by Medicare to the facility. This number will automatically print in Form Locator 7 on the UB-82.

PARAMETERS

7. MULTIPLE FORM TYPES	Set this field to YES if the facility uses more than one type of health insurance form. The UB and the HCFA-1500 are the form types currently available. If set to NO or left blank, only UB forms will be allowed.
8. DEFAULT AMB SURG REV CODE	When billing Billable Ambulatory Surgical Codes (BASC), this will be the default revenue code stored in the bill. If this is not appropriate for any particular insurance company, the AMBULATORY SURG. REV. CODE field in the INSURANCE COMPANY file can be entered and it will be used for that particular insurance company entry.
9. ASK HINQ IN MCCR	If this parameter is answered YES, you may be asked if you would like to put a HINQ request in the HINQ SUSPENSE file when creating a new bill on a veteran with unverified eligibility.
10. USE OP CPT SCREEN	CPT codes for outpatient visits are currently stored as ambulatory procedures in the SCHEDULING VISITS file. If this parameter is set to YES, all CPT codes stored in the SCHEDULING VISITS file for the date range of the bill will be displayed when editing a bill. This display screen will prompt the user if they would like to easily import any or all of the CPT codes into the bill. This will include both ambulatory procedures and the billable ambulatory surgical codes.

SECURITY KEYS

IB EDIT	Allows the holder to establish new billing records and edit existing records.
IB AUTHORIZE	Allows the holder to authorize generation of all bill form types.

MAIL MESSAGES

The following is an example of the mail message automatically sent when a bill is disapproved during the authorize phase of the billing process. Up to five reasons for disapproval may be listed in this message. If there are more than five reasons for disapproval, five reasons will be displayed followed by: "Other reasons too numerous to mention...".

```
Subj: MAS UB-82 BILL DISAPPROVAL BULLETIN  19 Apr 92 15:40  9 Lines
From: CHADWICK,MARJORIE  (Bronx VAMC) in 'IN' basket.
---------------------------------------------------------------------------

The following UB-82 bill has been disapproved:

Bill Number: 80009A

Patient Name: SPADE,ANTHONY                PT ID: 077-07-7777

Event Date: OCT 13,1991

Reason for disapproval: OTHER DIAGNOSES CODES UNSPECIFIED/INCORRECT


Select MESSAGE Action: IGNORE (in IN basket)//
```

DATA SUPPLEMENT, cont.

BILL MAILING ADDRESS

The following is an explanation of how the bill mailing address field on Screen 3 is determined.

WHO'S RESPONSIBLE	BILL MAILING ADDRESS IS
Patient	Patient's mailing address
Institution	
Institution has not been selected	Patient's mailing address
Institution has been selected	Institution's mailing address
Insurer	
Patient has no insurance company on file or more than one insurance company with none selected	No mailing address stored
Primary insurance company selected and bill is for inpatient stay and another company does not process the primary insurance company's inpatient claims	Primary insurance company's inpatient claims processing address
Primary insurance company selected and bill is for outpatient visit and another company does not process the primary insurance company's outpatient claims	Primary insurance company's outpatient claims processing address
Primary insurance company selected and bill is for inpatient stay and another company processes the primary insurance company's inpatient claims	Inpatient claims processing address of the company that processes the primary insurance company's inpatient claims
Primary insurance company selected and bill is for outpatient visit and another company processes the primary insurance company's outpatient claims	Outpatient claims processing address of the company that processes the primary insurance company's outpatient claims

DATA SUPPLEMENT, cont.

BILL MAILING ADDRESS

WHO'S RESPONSIBLE	BILL MAILING ADDRESS IS
Insurer, cont.	
Primary insurance company selected and the insured's employer should receive the insurance claims for pre-processing	Employer's claims processing address

If the mailing address is edited at any time, the edited address is stored. If a new rate type or insurance company is selected at any time, even if the mailing address has been edited, the mailing address will be determined as described above.

Automated Means Test Billing Menu
Cancel/Edit/Add Patient Charges

The Add a Charge action has been enhanced to allow you to add CHAMPUS copayment charges for prescriptions, inpatient care, and outpatient care. Three new Charge Types have been added to correspond to these types of charges.

 IB AUTHORIZE security key is required to access this option.

Introduction

The Cancel/Edit/Add Patient Charges option allows you to manually cancel, edit, or add per diem and copayment patient charges or fee services for a specified patient and date range. When a charge is edited, the original charge is canceled and a new charge is added. Once added or edited, the charges are passed to Accounts Receivable. You may receive Accounts Receivable mail messages when editing/canceling through this option.

You cannot add medication copayment charges for patients determined to be exempt from the medication copayment requirement.

You can choose whether or not to include pharmacy copay charges. Only pharmacy charges which have been added through this option can be edited or deleted through this option.

You can also choose to bill CHAMPVA inpatient subsistence charges for past admissions. (Current and future admissions will be billed automatically at discharge.) The CHAMPVA inpatient subsistence charge may be canceled through this option, but it will be canceled **only** in IB. You **must** go into the AR module to decrease the receivable to zero ($0).

Charges are displayed for the specified patient and date range and several "actions" can be taken against these charges. You can add/edit/cancel a charge, pass a charge to Accounts Receivable, change to another patient or date range, update an event by changing the event status, or change the date used to record the last date for which Means Test charges were billed for the admission.

List Manager actions are also available (i.e., First Screen, Last Screen, Up a Line, Down a Line, etc.). If you need help in using the List Manager functionality, please refer to the Appendix of this user manual.

Introduction, cont.

Once action has been taken on a charge, the screen is redisplayed showing the new data. If you have edited a charge, the status of the original entry is changed to CANCELLED, and two new entries are added. The first entry offsets the original charge (the amount appears in parentheses indicating a credit) and the new charge is shown.

Charges added or edited through this option are added/edited to the INTEGRATED BILLING ACTION file (#350). When adjustments are made through this option which affect the number of inpatient days or inpatient amount, you are prompted to choose whether or not you wish to make the adjustment to the Means Test Billing Clock.

Example

```
Select PATIENT NAME: AIELLO,FRANK        04-23-13     134097714    NO     NSC
Search for CHARGES from: NOV  5, 1992// <RET>  (NOV 05, 1992)
                      to: NOV  5, 1993// <RET>  (NOV 05, 1993)
Include RX COPAY charges? NO// <YES>



Charges                      Nov 05, 1993 10:19:52          Page:    1 of    1
Cancel/Edit/Add Charges                                  11/05/92 THRU 11/05/93
Patient: AIELLO,FRANK A7714
   Bill From  Bill To   Charge Type              Bill #  Status         Charge
1  12/12/92   12/12/92  OPT COPAY NEW                    ON HOLD         $33
2  02/01/93   02/21/93  INPT PER DIEM NEW        L10525  BILLED          $210
3  02/01/93   02/01/93  INPT COPAY (NEU) NEW     L10524  BILLED          $676
4  06/15/93   06/19/93  INPT PER DIEM NEW        L10525  BILLED          $50
5  10/12/93   10/12/93  OPT COPAY NEW            L10690  BILLED          $33
6  11/02/93   11/02/93  PSO NSC RX COPAY NEW     M10042  CANCELLED       $2
7  11/02/93   11/02/93  PSO NSC RX COPAY CANCEL  M10042  BILLED         ($2)

          Enter ?? for more actions
AC  Add a Charge          CP  Change Patient        UE  Update Event
EC  Edit a Charge         CD  Change Date Range
CC  Cancel a Charge       PC  Pass a Charge
Select Action: Quit// EC=2   Edit a Charge
```

Example, cont.

```
                          E D I T   A   C H A R G E
                            Processing Charge #2
------------------------------------------------------------------------------
   Name: AIELLO,FRANK                    Type: INPT PER DIEM NEW
     ID: 134-09-7714                      Amt: $210 (BILLED)
------------------------------------------------------------------------------

Select EDIT REASON: 14  ELIGIBILITY INCORRECT        14

  ** Active Billing Clock **
  Begin Date: 02/01/93   # Inpt Days: 26   1st 90 days: $676


Charge for services from: FEB  1, 1993// <RET>  (FEB 01, 1993)
  Charge for services to: FEB 21, 1993// 2 20 93  (FEB 20, 1993)

New charge to be billed: $200


Okay to edit this charge? Y  YES

Building the cancellation transaction...  .. done.

Building the updated transaction... done.

Means Test Billing Clock information for AIELLO,FRANK (7714)
------------------------------------------------------------------------------
  Clock Start Date: 02/01/93             Clock End Date: N/A
      Clock Status: CURRENT              Inpatient Days: 26

  Medicare Deductible Co-payments:
              1st 90 days: $676             3rd 90 days: $0
              2nd 90 days: $0               4th 90 days: $0
------------------------------------------------------------------------------

Update the number of inpatient days from 26 to 25? Y  YES
The clock has been updated.

Press RETURN to process the next charge or to return to the list: <RET>
Rebuilding list of charges...
```

Example, cont.

```
Charges                        Nov 05, 1993 10:19:52          Page:    1 of    1
Cancel/Edit/Add Charges                                  11/05/92 THRU 11/05/93
Patient: AIELLO,FRANK A7714
   Bill From  Bill To   Charge Type              Bill #  Status         Charge
1  12/12/92   12/12/92  OPT COPAY NEW                   ON HOLD         $33
2  02/01/93   02/21/93  INPT PER DIEM NEW       L10525  CANCELLED       $210
3  02/01/93   02/01/93  INPT COPAY (NEU) NEW    L10524  BILLED          $676
4  02/01/93   02/21/93  INPT PER DIEM CANCEL    L10525  UPDATED        ($210)
5  02/01/93   02/20/93  INPT PER DIEM UPDATE    L10525  BILLED          $200
6  06/15/93   06/19/93  INPT PER DIEM NEW       L10525  BILLED          $50
7  10/12/93   10/12/93  OPT COPAY NEW           L10690  BILLED          $33
8  11/02/93   11/02/93  PSO NSC RX COPAY NEW    M10042  CANCELLED       $2
9  11/02/93   11/02/93  PSO NSC RX COPAY CANCEL M10042  BILLED         ($2)

          Enter ?? for more actions
AC  Add a Charge          CP  Change Patient        UE  Update Event
EC  Edit a Charge         CD  Change Date Range
CC  Cancel a Charge       PC  Pass a Charge
Select Action: Quit//
```

Automated Means Test Billing Menu
Patient Billing Clock Maintenance

INTRODUCTION

This option allows adding or editing of patient billing clocks. Most often this option will be used to add or edit clocks of patients transferred from other facilities. The following fields are editable: clock begin date, status, 90 day inpatient amounts, and number of inpatient days. A free text field to include a reason for the update is also provided.

The fields contained in this option are used to determine, and directly affect, the copayment charges billed to the patient for care received. These fields can also be affected by other options such as the Cancel/Edit/Add Patient Charges option. For further details, please see that option documentation. The clock will automatically be closed after 365 days or on the date the patient is no longer Category C, whichever is earlier. Billing clocks which may have been "left open" due to a lack of billable activity will be closed during the nightly compilation job which is run automatically. Billing clocks which must be deleted for any reason will have a status of CANCELLED.

Only holders of the IB AUTHORIZE security key can access this option.

The chart beginning on the following page shows the prompts and steps involved in using this option.

Automated Means Test Billing Menu
Patient Billing Clock Maintenance

PROCESS

The following chart shows the prompts and steps involved in using the Patient Billing Clock Maintenance option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select PATIENT:	.patient with active billing clock	2
		.patient with no active clock	3
		.<RET> or up-arrow <^>	9
	Billing clock information is displayed for the selected patient.		
2	Do you want to update?	.YES	4
		.NO	1
3	This patient does not have an active billing clock! Is is okay to add a new billing clock for this patient?	.YES	4
		.NO	1
	Steps 4 through 7 might appear with defaults if you are editing an existing clock. You can <RET> to accept the default or enter new data.		
4	CLOCK BEGIN DATE:	.date the billing clock should begin	5
5	STATUS:	.1 for CURRENT	6
		.2 for CLOSED	6
		.3 for CANCELLED	6
		.<RET> (no default)	6
	If the number of inpatient days is greater than 90, this prompt will repeat for each 90 day inpatient amount.		
6	{1ST/2ND/3RD/4TH} 90 DAY INPATIENT AMOUNT:	.the total copayment amount (excluding the per diem charge) which has been billed to the patient for this 90 days of care	6 or 7
		.<RET> (no default)	7

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
7	NUMBER INPATIENT DAYS:	.total number of days the patient has spent in the hospital/nursing home since the clock begin date	8
8	UPDATE REASON:	.reason for the update (3-40 characters)	1
9	Return to the menu.		

Automated Means Test Billing Menu
Patient Billing Clock Maintenance

EXAMPLE
The following is an example of what might appear on your screen while using the Patient Billing Clock Maintenance option. User responses are shown in boldface type.

```
Select PATIENT: KAGAN,PETER    10-10-55    322278665   NSC VETERAN


REFERENCE NUMBER: 500341                PATIENT: KAGAN,PETER
  CLOCK BEGIN DATE: MAR  1, 1992        STATUS: CURRENT
  1ST 90 DAY INPATIENT AMOUNT: 628      NUMBER INPATIENT DAYS: 10
  USER ADDING ENTRY: GRAY,MARTIN        DATE ENTRY ADDED: MAR 12, 1992

Do you want to update? YES
CLOCK BEGIN DATE: MAR 1,1992// 4/1  (APR 01, 1992)
STATUS: CURRENT// <RET>
1ST 90 DAY INPATIENT AMOUNT: 628// <RET>
NUMBER INPATIENT DAYS: 10// <RET>
UPDATE REASON: correct clock begin date
```

Automated Means Test Billing Menu
Estimate Category C Charges for an Admission

INTRODUCTION

This option is used to estimate the Means Test/Category C charges for an episode of hospital or nursing home care for a proposed length of stay. It can also be used to estimate charges to be billed to a current inpatient for the remainder of his/her stay.

The report will indicate whether or not the patient has an active billing clock, the start date, and the number of inpatient days of care within that clock.

If a patient has an active clock and has already been charged a copayment for the current 90 days of inpatient care, that amount billed is shown. Also provided is the amount of copay and per diem that would be billed for this proposed episode of care. For a complete description of all data provided in this output, please refer to the data supplement at the end of this option documentation.

The chart on the following page shows the prompts and steps involved in using this option.

Automated Means Test Billing Menu
Estimate Category C Charges for an Admission

PROCESS
The following chart shows the prompts and steps involved in using the Estimate Category C Charges for an Admission option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select PATIENT NAME:	.patient name or SSN .<RET> or up-arrow <^>	2 7
2	If the selected patient is currently an inpatient and Category C charges have already been calculated for this stay, the following message will appear and you will proceed to Step 4. Otherwise you will proceed to Step 3. "Please note that this patient was admitted on {DATE} and Category C charges have been calculated through {DATE}."		4
3	Proposed ADMISSION Date:	.date estimated length of stay will begin (if the year is omitted, the system assumes a date in the past)	4
4	Proposed DISCHARGE Date:	.the date the estimated length of stay will end	5
	This step will not appear if the patient is currently an inpatient and Category C charges have already been calculated for this stay.		
5	Anticipated Facility Treating Specialty:	.the treating specialty for this anticipated episode of care .<??> for a list of specialties	6
6	You will be prompted for a device at this prompt.		
7	Return to the menu.		

Automated Means Test Billing Menu
Estimate Category C Charges for an Admission

EXAMPLE

The following is an example of what may appear on the screen while using the Estimate Category C Charges for an Admission option followed by a sample output. User responses are shown in boldface type.

```
Select PATIENT NAME:    KAGAN,PETER    07-07-40   442121211     NSC VETERAN
Proposed ADMISSION Date: T  (FEB 25, 1992)
Proposed DISCHARGE Date: T+4  (FEB 29, 1992)
Anticipated Facility Treating Specialty:  OPHTHALMOLOGY     OPHTHALMOLOGY   53
DEVICE: HOME//  A137  HP LASER    RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)



Estimated Category C Inpatient Charges for KAGAN,PETER   1211

Charges will be estimated from 02/25/92 through 02/29/92.

** THIS PATIENT HAS AN ACTIVE BILLING CLOCK **
      Clock date: 12/20/91   Days of inpatient care within clock:   2
      Copayments made for current 90 days of inpatient care:  $628.00

COPAYMENT CHARGES for SURGICAL CARE
-------------------------------------------------------------------------------
   Billing Dates           Inpt. Days        Clock Days
  From         To         1st     Last      1st     Last          Charge
-------------------------------------------------------------------------------
02/20/92    02/25/92        1        1       72       72          $24 00
                                                               ----------
                                                                   $24 00
PER DIEM CHARGES for HOSPITAL CARE
-------------------------------------------------------------------------------
02/25/92    02/28/92      4 days  @ $10.00/day                     $40.00
                                                               ----------
                                  Total Estimated Charges:         $64.00
```

Automated Means Test Billing Menu
Estimate Category C Charges for an Admission

DATA SUPPLEMENT

Data Element	**Description**
CLOCK DATE	Date the current billing clock began for this patient.
DAYS OF INPATIENT CARE WITHIN CLOCK	Number of days of inpatient care within the current billing clock.
COPAYMENTS MADE FOR CURRENT 90 DAYS OF INPATIENT CARE	Total amount of copayment made for the current 90 days of inpatient care for the current billing clock.
COPAYMENT CHARGES FOR {type of care}	Amount of the copayment charge for this proposed inpatient stay. The copayment charge differs depending on the type of inpatient care; however, it will not exceed the current Medicaid deductible. Once the deductible is met, the patient is covered for a 90 day period. For the second, third and fourth 90 days of hospital care, the copayment charge is half of the current Medicaid deductible. For other than hospital care (i.e., NHCU), the full deductible applies for each 90 days of care.
BILLING DATES {FROM/TO}	Date(s) the copayment occurred. If the proposed episode of care was for a total of five days (2/1/92 - 2/5/92) but the deductible was met the first day, the billing dates (from and to) would reflect the first day only (2/1/92).

DATA SUPPLEMENT, cont.

Data Element	**Description**
INPATIENT DAYS {1st/Last}	On which days of the current 90 days of inpatient care this copayment occurred. If the patient previously had two days of inpatient care in the current 90 days and the deductible was met the first day of this proposed episode of care, the "inpatient days" would reflect day three as the days (1st and last) this copayment was incurred.
CLOCK DAYS {1st/Last}	On which days of the current billing clock this copayment was incurred. If the current billing clock began on 2/1/92 and the copayment for this proposed episode of care was incurred on 2/15 and 2/16/92, the "clock days" would reflect day 15 for the 1st and day 16 for the last.
CHARGE	Amount of the copayment or per diem charge for this proposed episode of care.
PER DIEM CHARGES FOR {type of care}	A daily charge for the inpatient stay. No charge is incurred for the day of discharge (i.e., if the proposed inpatient stay is 2/1/92 thru 2/5/92 and the per diem rate is $10.00, the total per diem charge would be $40.00).
TOTAL ESTIMATED CHARGES	Total of the copayment and the per diem charges for the proposed inpatient stay.

Automated Means Test Billing Menu
Add/Edit Pts. Continuously Hospitalized Since 1986

INTRODUCTION

This option allows you to add or edit entries in the CONTINUOUS PATIENT file (#351.1) for patients continuously hospitalized at the same level of care since 1986. These patients are exempt from the copayment portion of the Means Test, but may still be charged per diem.

The CONTINUOUS PATIENT file is populated during the post-init and is updated as continuous patients are discharged. This option is only used if the file is in error or under unusual circumstances, such as the transfer-in of a continuous patient.

In order to be considered a continuous patient, there must not be a discharge date in the CONTINUOUS PATIENT file for the patient. By entering or deleting a discharge date, you change the patient's status.

Only holders of the IB AUTHORIZE security key can access this option.

Due to the brevity of this option, no process chart is provided.

Automated Means Test Billing Menu
Add/Edit Pts. Continuously Hospitalized Since 1986

EXAMPLE
The following examples show what might appear on your screen while using this option. User responses are shown in boldface type.

EXAMPLE 1
A new patient is added to the CONTINUOUS PATIENT file.

```
Select PATIENT: KAGAN,PETER          12-12-55     112324541     NSC VETERAN
   ARE YOU ADDING 'KAGAN,PETER' AS A NEW IB CONTINUOUS PATIENT (THE 13TH)? Y
(YES)
DISCHARGE DATE: <RET>
```

EXAMPLE 2
A discharge date is entered for the patient, and he is no longer considered a continuous patient.

```
Select PATIENT: KAGAN,PETER          12-12-55     112324541     NSC VETERAN
         ...OK? YES// <RET>  (YES)
DISCHARGE DATE: 5/1  (MAY 01, 1992)
```

EXAMPLE 3
The discharge date is deleted. The patient may again be considered a continuous patient.

```
Select PATIENT: KAGAN,PETER          12-12-55     112324541     NSC VETERAN
         ...OK? YES// <RET>  (YES)
DISCHARGE DATE: MAY 1,1992// @
   SURE YOU WANT TO DELETE? Y  (YES)
```

Automated Means Test Billing Menu
On Hold Menu
Held Charges Report

INTRODUCTION

The Held Charges Report provides you with a list of all charges with a status of ON HOLD. Charges for Category C patients with insurance are placed on hold until the patient's insurance company bill is resolved. When payment is received from the insurance carrier, the status of the charge is updated through the Release Charges 'On Hold' option.

This report can be used to insure that there is an insurance bill established for each charge on hold, and to identify charges that should be released when payments are received from insurance carriers.

The following information is provided: patient name and ID, action ID, type of charge, bill number, the from and to dates, and the corresponding charge. If there is a corresponding insurance bill, the bill number, A/R status, charge amount, and amount paid are also provided.

Due to the brevity of this option, no process chart is provided.

Automated Means Test Billing Menu
On Hold Menu
Held Charges Report

EXAMPLE
The following example shows what might appear on your screen while using this option followed by a sample output. User responses are shown in boldface type.

```
*** Margin width of this output is 132 ***
*** This output should be queued ***
DEVICE: HOME// A137    HALLWAY HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW// T@1800 (MAY 26, 1992@18:00:00)
REQUEST QUEUED TASK=5687
```

```
                                        CATEGORY C CHARGES ON HOLD                    MAY 26,1992  PAGE 1
HELD CHARGES                                                                  CORRESPONDING THIRD PARTY BILLS
=============================================================================||==============================
Name           Pt.ID  ActionID  Type   Bill#   From       To          Charge || Bill#    AR-Status  Charge    Paid
=============================================================================||==============================
BAKER,DAN      0540   500942    OPT    L10220  03/01/92   03/11/92     30.00 || L10209   NEW BILL   148.00    0.00
                      500948    INPT   L10233  03/11/92   03/14/92    652.00 ||
                      500954    OPT    L10229  03/11/92   03/11/92     30.00 ||
CANNEL,STAN    4949   5002661   OPT    L10305  05/08/92   05/08/92     30.00 ||
COOPER,ROBERT  1232   5001488   OPT    L10259  04/07/92   04/07/92     30.00 ||
                      5001512   OPT    L10259  04/03/92   04/03/92     30.00 || L10342   NEW BILL   296.00     0.0
DAVIS,JOHN     3035   5002673   INPT   L10304  05/19/92   05/19/92    238.00 ||
LOMBARDO,VITO  0823   5001449   INPT   L10178  03/01/92   03/01/92    652.00 || L10235   NEW BILL  5736.00    0.00
STEINER,JOHN   3434   5001476   INPT   L10261  04/13/92   04/16/92    652.00 ||
WARREN,JAMES   3232   5001024   OPT    L10121  03/23/92   03/23/92     30.00 || L10329   NEW BILL   740.00    0.00
                      5001025   OPT    L10121  03/23/92   03/23/92     30.00 ||
                      5001026   OPT    L10121  03/23/92   03/23/92     30.00 ||
                      5001029   OPT    L10121  03/23/92   03/23/92     30.00 ||
                      5001030   OPT    L10121  03/23/92   03/23/92     30.00 ||
```

Automated Means Test Billing Menu
On Hold Menu
Release Charges 'On Hold'

INTRODUCTION

The Release Charges 'On Hold' option is used to release Means Test Category C charges, with a status of ON HOLD, to Accounts Receivable. This option is also available on the Agent Cashier's Menu in Accounts Receivable.

If the HOLD MT BILL W/INS parameter is set to YES, inpatient and outpatient copayments for Category C patients with insurance will automatically be placed on hold. These charges will not be passed to Accounts Receivable until they are released through this option. Please note that the $5/$10 hospital/NHCU per diem charges are not placed on hold.

If the original bill number is no longer open when the charge is passed to Accounts Receivable, a new bill number is assigned.

Only holders of the IB AUTHORIZE security key can access this option.

The chart on the following page shows the steps and prompts involved in using this option.

Automated Means Test Billing Menu
On Hold Menu
Release Charges 'On Hold'

PROCESS
The following chart shows the prompts and steps involved in using the Release Charges 'On Hold' option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	"This option is used to release Means Test/Category C charges which have been placed 'on hold'. Please enter a patient with charges 'on hold', and these charges will be displayed and may be selected to be released to Accounts Receivable."		
	Select PATIENT NAME:	.name	2
		.<??> for a list of patients with charges on hold	1
		.<RET> or up-arrow <^>	5
	All charges for the selected patient with a status of ON HOLD are displayed for selection.		
2	Select IB Actions (REF #) to release (or '^' to exit):	.reference number(s) of IB action(s) you wish to release to accounts receivable	3
3	OK to pass these charges to Accounts Receivable?	.YES	4
		.NO	1
	The charges which were passed to Accounts Receivable are displayed. If the original bill number is no longer open when the charge is passed to Accounts Receivable, a new bill number is assigned.		
4	Press RETURN to continue or '^' to exit:	.<RET> or up-arrow <^>	1
5	Return to the menu.		

Automated Means Test Billing Menu
On Hold Menu
Release Charges 'On Hold'

EXAMPLE
The following example shows what might appear on your screen while using this option. User responses are shown in boldface type.

```
This option is used to release Means Test/Category C charges which have been
placed 'on hold.'  Please enter a patient with charges 'on hold,' and these
charges will be displayed and may be selected to be released to Accounts
Receivable.

Select PATIENT NAME: KAGAN,PETER       12-12-55     112324541     NSC VETERAN



KAGAN,PETER      Pt ID: 112-32-4541
--------------------------------------------------------------------------------

The following IB Actions for this patient are ON HOLD:
================================================================================
 REF   Action ID  Bill Type               Bill #     From       To      Charge
================================================================================
  1      5001528  OUTPATIENT COPAY        L10056   04/01/92  04/01/92   30.00
  2      5001612  OUTPATIENT COPAY        L10056   05/04/92  05/04/92   30.00
  3      5002638  FEE SERVICE/INPATIENT   L10092   01/01/92  01/02/92   50.00
  4      5002654  OUTPATIENT COPAY        L10302   05/15/92  05/15/92   30.00

Select IB Actions (REF #) to release (or '^' to exit): 1,2
OK to pass these charges to Accounts Receivable? Y  YES

Passing charges to Accounts Receivable...

================================================================================
 REF   Action ID  Bill Type               Bill #     From       To      Charge
================================================================================
  1      5001528  OUTPATIENT COPAY        L10056   04/01/92  04/01/92    30.00
  2      5001612  OUTPATIENT COPAY        L10056   05/04/92  05/04/92    30.00

The charges listed above have been passed to Accounts Receivable.


Press RETURN to continue or '^' to exit:
```

Automated Means Test Billing Menu
On Hold Menu
List Charges Awaiting New Copay Rate

INTRODUCTION

The List Charges Awaiting New Copay Rate option is used to generate a list of all Means Test outpatient copayment charges which have been placed on hold because the copay rate is over one year old.

New billing rates are scheduled to be released from VA Central Office at the beginning of each fiscal year (10/1). However, there may be a delay in the release of these new rates. If the rate on file for the Means Test outpatient copayment charge is over one year old at the time the bill is created, these charges will be held until the new copay rate is entered. When the rate is entered, you are given the opportunity to release the charges to Accounts Receivable at that time or they can be released through the Release Charges Awaiting New Copay Rate option.

Entries on the output will be listed in alphabetical order by patient name. Information provided includes patient name, last four digits of the patient ID, visit date, and charge.

The only prompt is for a device. Due to the brevity of this option, a process chart has not been provided.

Automated Means Test Billing Menu
On Hold Menu
List Charges Awaiting New Copay Rate

EXAMPLE
The following is an example of what may appear on your screen while using the List Charges Awaiting New Copay Rate option followed by an example of the output. User responses appear in boldface type.

```
Select On Hold Menu Option: list  List Charges Awaiting New Copay Rate
DEVICE: HOME// <RET>   LAT    RIGHT MARGIN: 80// <RET>


              LIST OF ALL OUTPATIENT COPAYMENT CHARGES 'ON HOLD'
                  AWAITING ENTRY OF THE NEW COPAYMENT RATE
                                                                    Page: 1
                                                                Run Date: 10/18/93
--------------------------------------------------------------------------------
Patient Name (ID)                        Visit Date          Charge
--------------------------------------------------------------------------------

BACALL,HUMPHREY  (0540)                    10/08/93           $33
DERDERIAN,TIM O  (1827)                    10/12/93           $33
SMITH,IRENE  (0440)                        10/05/93           $33
                                           10/04/93           $33
SRAY,PETER  (0707)                         10/01/93           $33
VISKERS,PAUL  (8591)                       10/05/93           $33
```

Automated Means Test Billing Menu
On Hold Menu
Send Converted Charges to A/R

INTRODUCTION

This option is designed for use after the Integrated Billing conversion is completed. After the conversion, certain inpatient and outpatient charges will have a status of CONVERTED. This option allows you to choose which converted charges are passed to Accounts Receivable. Only holders of the IB AUTHORIZE security key can access this option.

During the conversion, the BILLS/CLAIMS file (#399) is checked to insure that each outpatient visit has been billed. For each visit without an established bill, one is established and given a status of CONVERTED. The conversion cannot determine whether or not an episode of care has been billed for inpatients; therefore, all billable inpatient episodes are provided a status of CONVERTED and you must determine which ones should be passed.

You can choose to pass the charges by patient or date. If patient is selected, all billing actions with a status of CONVERTED are displayed. You can then select which actions will be passed to accounts receivable. If date is selected, all outpatient copay and fee service billing actions that were created on or before the selected date are passed to accounts receivable.

If the HOLD MT BILL W/INS parameter at your site is set to YES, inpatient and outpatient copayments for Category C patients with insurance will automatically be placed on hold. These charges **will not** be passed to Accounts Receivable until they are released through the Release Charges 'On Hold' or Cancel/Edit/Add Patient Charges options. You may wish to set this parameter to NO until all charges that should be passed to A/R are passed.

This option is being distributed as "**out of order**" as it is no longer needed and will probably be deleted in the next release of Integrated Billing.

The chart beginning on the following page shows the prompts and steps involved in using the Send Converted Charges to A/R option.

Automated Means Test Billing Menu
On Hold Menu
Send Converted Charges to A/R

PROCESS
The following chart shows the prompts and steps involved in using the Send Converted Charges to A/R option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Pass converted charges by Patient or by Date (P/D):	.P to select charges by patient	2
		.D to select by cutoff date	6
		.<RET> or up-arrow <^>	9
2	"This option is used to pass Means Test/Category C charges which have been converted. Please enter a patient with converted charges and these charges will be displayed and may be selected to be released to Accounts Receivable."		
	Select PATIENT NAME:	.patient name	3
		.<??> for list of all patients with converted charges	2
	All converted charges for the selected patient are displayed for selection.		
3	Select IB Actions (REF #) to pass (or '^' to exit):	.reference number(s) of the charge(s) you wish to pass to A/R	4
4	OK to pass these charges to Accounts Receivable: YES//	.<RET> to accept default and pass the charges	5
		.NO if you do not wish to pass the charges	9

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	If the HOLD MT BILL W/INS parameter at your site is set to YES, inpatient and outpatient copayments for Category C patients with insurance will automatically be placed on hold. These charges **will not** be passed to Accounts Receivable until they are released through the Release Charges 'On Hold' or Cancel/Edit/Add Patient Charges options. At this step, the charges are redisplayed with a bill number or new status of ON HOLD along with the following message, "The charge{s} listed above {has/have} been passed to Accounts Receivable". If any of the charges that attempted to pass to A/R were given a status of ON HOLD, the following message is also displayed,"* Please note that charges placed 'On Hold' are still pending release from Integrated Billing".		
5	Select Another Patient: YES//	.<RET> to accept default .NO	2 9
6	Enter Cutoff date for Converted Charges:	.date (all converted charges created on or before this date will be included)	7
	If the HOLD MT BILL W/INS parameter at your site is set to YES, inpatient and outpatient copayments for Category C patients with insurance will automatically be placed on hold. These charges **will not** be passed to Accounts Receivable until they are released through the Release Charges 'On Hold' or Cancel/Edit/Add Patient Charges options.		
7	There are [{#}] charges to be passed to accounts receivable Do you wish to pass these charges to accounts receivable (Y/N):	.YES to pass the charges to Accounts Receivable .NO	8 9

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
8	Requested Start Time: NOW//	.<RET> to accept default	9
		.date and time to begin	9
9	Return to the menu.		

Automated Means Test Billing Menu
On Hold Menu
Send Converted Charges to A/R

EXAMPLE
The following example shows what might appear on your screen while using this option. User responses are shown in boldface type.

```
Pass converted charges by Patient or by Date (P/D): P


This option is used to pass Means Test/Category C charges which have been
converted. Please enter a patient with converted charges and these
charges will be displayed and may be selected to be released to Accounts
Receivable.


Select PATIENT NAME: KAGAN,PETER       10-10-25     112101011     NSC VETERAN


KAGAN,PETER      Pt ID: 112-10-1011
--------------------------------------------------------------------------------

The following IB Actions for this patient, are CONVERTED CHARGES:
================================================================================
 REF   Action ID  Bill Type                  From      To        Charge
================================================================================
  1       500466  OUTPATIENT COPAY        11/02/90  11/02/90     26.00
  2       500575  OUTPATIENT COPAY        01/09/91  01/09/91     20.00

Select IB Actions (REF #) to pass (or '^' to exit): 1,2
OK to pass these charges to Accounts Receivable: YES// <RET>

Passing charges to Accounts Receivable...

================================================================================
                                          Bill # or
 REF   Action ID  Bill Type               On Hold    From       To      Charge
================================================================================
  1       500466  OUTPATIENT COPAY        On Hold  11/02/90  11/02/90    26.00
  2       500575  OUTPATIENT COPAY        On Hold  01/09/91  01/09/91    20.00

The charges listed above have been passed to Accounts Receivable.

* Please note that charges placed 'On Hold' are still pending release from
  Integrated Billing.

Select Another Patient: YES// <RET>

Select PATIENT NAME:
```

Automated Means Test Billing Menu
On Hold Menu
Release Charges 'Pending Review'

INTRODUCTION

The Release Charges 'Pending Review' option is used to review charges which have been created when an Income Verification Match (IVM) verified Means Test has been received and filed at the medical facility. If such a Means Test results in changing the patient's Means Test status from Category A to Category C, copayment and per diem charges for previous episodes of care will automatically be created. The charges will not be automatically passed to Accounts Receivable but will be held in Billing until a review of the charges is complete. A mail message is sent to the Category C Billing mail group notifying users that the charges have been created and are pending review.

After review, you may pass the charges to Accounts Receivable for billing or cancel the charges. If passed to AR, the billing information will also be passed to the IVM software which will in turn transmit it to the IVM Center in Atlanta.

Since the billing clock was updated when the charge was originally built, you may need to update the billing clock if the charge is cancelled. This can be accomplished through the Patient Billing Clock Maintenance option.

Due to the nature of this option, no process chart is provided.

Automated Means Test Billing Menu
On Hold Menu
Release Charges 'Pending Review'

EXAMPLE
The following examples show what might appear on the screen when using the Release Charges 'Pending Review' option.

Example 1 - Cancel Charge

```
Patient List                Aug 04, 1994 07:30:20          Page:    1 of    1
Release Charges 'Pending Review'
                                                 Date of     Current       Active
    Patient Name                          Pt ID  Ver. MT     MT Cat.        Ins?
1   WILLIS,KATIE                          W5424  04/11/93    REQUIRED        NO
2   ZONICH,PAUL                           Z8877  06/14/93    REQUIRED        NO


          Enter ?? for more actions
SP  Select Patient
Select Action: Quit// SP   Select Patient
Select Patient(s): (1-2): 1
Generating a list of pending charges for WILLIS,KATIE ...


Held Charge List            Aug 04, 1994 07:34:22          Page:    1 of    1
Release Charges 'Pending Review'                    List of all Pending Charges
Patient: WILLIS,KATIE  W5424                                          Date
   Bill From   Bill To     Charge Type                    Charge      Created
1  06/13/93    06/13/93    OPT COPAY NEW                  $36         07/28/94


          Enter ?? for more actions
PC  Pass Charge           CC  Cancel Charge
Select Action: Quit// CC   Cancel Charge
Select CANCELLATION REASON: 4  ENTERED IN ERROR        4

Okay to cancel this charge? YES
Charge #1 has been cancelled.

Means Test Billing Clock information for WILLIS,KATIE (5424)
------------------------------------------------------------------------------
  Clock Start Date: 06/13/93              Clock End Date: N/A
      Clock Status: CURRENT               Inpatient Days: 0

  Medicare Deductible Co-payments:
               1st 90 days: $0               3rd 90 days: $0
               2nd 90 days: $0               4th 90 days: $0
------------------------------------------------------------------------------

Since the billing clock was updated when the charge was originally built,
you may now need to update this clock since the charge has been cancelled.
```

EXAMPLE, cont.

```
Press RETURN to continue or '^' to exit: <RET>


Held Charge List            Aug 04, 1994 07:34:45          Page:    1 of    1
Release Charges 'Pending Review'                    List of all Pending Charges
Patient: WILLIS,KATIE  W5424                                          Date
   Bill From   Bill To     Charge Type                    Charge      Created

  There are no charges pending review for this patient.


          Enter ?? for more actions
PC  Pass Charge           CC  Cancel Charge
Select Action: Quit// <RET>   QUIT



Patient List                Aug 04, 1994 07:35:22          Page:    1 of    1
Release Charges 'Pending Review'
                                                 Date of     Current       Active
    Patient Name                        Pt ID    Ver. MT     MT Cat.        Ins?
1   ZONICH,PAUL                         Z8877    06/14/93    REQUIRED        NO


          Enter ?? for more actions
SP  Select Patient
Select Action: Quit// <RET>   QUIT



Example 2 - Pass Charge

Patient List                Aug 04, 1994 07:30:20          Page:    1 of    1
Release Charges 'Pending Review'
                                                 Date of     Current       Active
    Patient Name                        Pt ID    Ver. MT     MT Cat.        Ins?
1   WILLIS,KATIE                        W5424    04/11/93    REQUIRED        NO


          Enter ?? for more actions
SP  Select Patient
Select Action: Quit// SP   Select Patient
Generating a list of pending charges for WILLIS,KATIE ...
```

Automated Means Test Billing Menu
On Hold Menu
Release Charges 'Pending Review'

EXAMPLE, cont.

```
Held Charge List            Aug 04, 1994 07:34:22          Page:    1 of    1
Release Charges 'Pending Review'                    List of all Pending Charges
Patient: WILLIS,KATIE  W5424                                          Date
   Bill From   Bill To     Charge Type                    Charge      Created
1  06/13/93    06/13/93    OPT COPAY NEW                  $36         07/28/94


          Enter ?? for more actions
PC  Pass Charge           CC  Cancel Charge
Select Action: Quit// PC   Pass Charge

Okay to pass this charge? YES
Charge #1 has been passed to Accounts Receivable.

Press RETURN to continue or '^' to exit: <RET>



Held Charge List            Aug 04, 1994 07:34:45          Page:    1 of    1
Release Charges 'Pending Review'                    List of all Pending Charges
Patient: WILLIS,KATIE  W5424                                          Date
   Bill From   Bill To     Charge Type                    Charge      Created

  There are no charges pending review for this patient.


          Enter ?? for more actions
PC  Pass Charge           CC  Cancel Charge
Select Action: Quit// <RET>   QUIT



Patient List                Aug 04, 1994 07:35:22          Page:    1 of    1
Release Charges 'Pending Review'
                                                 Date of     Current       Active
    Patient Name                       Pt ID     Ver. MT     MT Cat.        Ins?

  There are no patients with charges pending review.


          Enter ?? for more actions
SP  Select Patient
Select Action: Quit// <RET>   QUIT
```

Automated Means Test Billing Menu
On Hold Menu
Release Charges Awaiting New Copay Rate

INTRODUCTION The Release Charges Awaiting New Copay Rate option is used to release charges which have been placed on hold because the outpatient copay rate is over one year old.

New billing rates are scheduled to be released from VA Central Office at the beginning of each fiscal year (10/1). However, there may be a delay in the release of these new rates. If the rate on file for the Means Test outpatient copayment charge is over one year old at the time the bill is created, these charges will be held until the new copay rate is entered. When the rate is entered, you are given the opportunity to release the charges to Accounts Receivable at that time or they can be released through this option. You will be prompted to task off a job which will automatically update the dollar amount and bill all such charges. The user will receive a message when the tasked job has completed.

If the copay rate currently in your Billing Table is too old to use, the following message will appear.

"The current copay rate (effective {date}) is still too old to use. Please be sure that you have entered the most current rate in your Billing Rates table."

Due to the brevity of this option, a process chart has not been provided.

Automated Means Test Billing Menu
On Hold Menu
Release Charges Awaiting New Copay Rate

EXAMPLE
The following is an example of what may appear on your screen while using the Release Charges Awaiting New Copay Rate option. User responses appear in boldface type. An example of the mail message generated by this option follows.

```
Select On Hold Menu Option: wait  Release Charges Awaiting New Copay Rate

There are 8 charges on hold, awaiting the new copay rate.
Do you want to queue a job to automatically bill these held charges? YES
Requested Start Time: NOW// <RET>   (NOV 02, 1993@14:34:18)

This job has been queued.  The task number is 432.
```

```
MailMan message for HENDERSON,BARRY     BILLING CLERK
Printed at VAMC AUGUSTA GA   02 Nov 93 14:36
Subj: BILLING OF MEANS TEST CHARGES AWAITING NEW COPAY RATE [#170056]
02 Nov 93 14:34   8 Lines
From: INTEGRATED BILLING PACKAGE  in 'IN' basket.   Page 1
---------------------------------------------------------------------------

The job to automatically bill Means Test Outpatient copayment charges
which were on hold, awaiting the new copayment rate, has just completed.

          Job Start Time: NOV  2, 1993 at 14:34:18
            Job End Time: NOV  2, 1993 at 14:34:47

Number of charges billed: 8
There are no longer any charges awaiting the new copay rate which are on hold.
```

Automated Means Test Billing Menu
Patient Billing Clock Inquiry

INTRODUCTION

This option allows you to display data contained in the patient billing clock. It can be used to view the number of inpatient days and amount billed for inpatient copayments for Category C patients.

When the patient is selected, all billing clocks for that patient are displayed. The reference number, patient name, and the cycle begin date are provided. Once a clock is selected, information such as the clock status, primary eligibility code, cycle begin and end dates, number of inpatient days, and 90 day inpatient amounts are displayed.

Due to the brevity of this option, no process chart is provided.

Automated Means Test Billing Menu
Patient Billing Clock Inquiry

EXAMPLE
The following example shows what might appear on your screen while using this option followed by a sample output. User responses are shown in boldface type.

```
Select CAT C Billing Clock by PATIENT NAME: GRAVES,ADAM       03-02-21
097098067     NSC VETERAN
     1     500333        GRAVES,ADAM      05-11-90
     2     500986        GRAVES,ADAM      01-29-92
TYPE '^' TO STOP, OR
CHOOSE 1-2:2

DEVICE: HOME// <RET>  Decnet    RIGHT MARGIN: 80// <RET>



GRAVES,ADAM             342-95-7333     MAR  2,1921     NSC VETERAN
================================================================================
      Reference Number:  500986
                Status:  CURRENT

    Primary Elig. Code:  NSC

      Cycle Begin Date:  JAN 29,1992
        Cycle End Date:

 Number Inpatient Days:  3

 90 Day Inpatient Amounts
     1st 90 Day Amount:  628.00
     2nd 90 Day Amount:
     3rd 90 Day Amount:
     4th 90 Day Amount:

      Date Entry Added:  FEB 12,1992
     Date Last Updated:

         Update Reason:

Press RETURN to continue or '^' to exit: <RET>


Select CAT C Billing Clock by PATIENT NAME:
```

Automated Means Test Billing Menu
Category C Billing Activity List

INTRODUCTION

The Category C Billing Activity List option is used to list all Means Test/Category C charges within a specified date range. The list is alphabetical by patient name.

This output provides the patient name and ID, a brief description, the status and the billing period for the bill, the units (the number of days a charge occurred), and the amount of the charge. For inpatient copay charges, the description includes the treating specialty for the episode of care.

As stated above, the units reflect the number of days a charge occurred. For inpatient copay charges the unit will always be one, even if the patient accrued the charges over a number of days before the Medicaid deductible was met.

You will be prompted for a date range and device.

Due to the brevity of this option, a process chart is not provided.

Automated Means Test Billing Menu
Category C Billing Activity List

EXAMPLE
Below is an example of what may appear on the screen while using the Category C Billing Activity List option followed by a sample output. User responses are shown in boldface type.

```
Start with DATE: 1/1  (JAN 01, 1992)
Go to DATE: T  (FEB 26, 1992)
DEVICE: HOME// A137   HP LASER    RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

```
Category C Billing Activity List             FEB 26, 1992@09:14:28     Page: 1
Charges from 01/01/92 through 02/26/92
PATIENT/ID        DESCRIPTION       STATUS         FROM       TO    UNITS CHARGE
-------------------------------------------------------------------------------
KAGAN,PETER 2086  INPT PER DIEM     BILLED       01/02/92  01/03/92  2   $20.00
                  INPT COPAY (ALC)  BILLED       01/02/92  01/03/92  1  $476.00
MCBRIDE,NED 8745  OPT COPAY         PENDING A/R  02/11/92  02/11/92  1    $0.00
MOORE,TIM   8761  INPT PER DIEM     BILLED       01/13/92  01/14/92  2   $20.00
                  INPT COPAY (MED)  BILLED       01/13/92  01/14/92  1  $652.00
NELSON,KEN  0978  OPT COPAY         PENDING A/R  02/12/92  02/12/92  1    $0.00
PAUL,JOHN   9065  OPT COPAY         BILLED       02/17/92  02/17/92  1   $30.00
RICH,DAN    1243  OPT COPAY         BILLED       02/13/92  02/13/92  1   $30.00
SIMS,HAROLD 1122  INPT PER DIEM     BILLED       01/13/91  01/18/92  6   $60.00
                  INPT COPAY (MED)  BILLED       01/13/92  01/18/92  1   $24.00
VOIT,RICK   9467  OPT COPAY         BILLED       02/12/92  02/12/92  1   $30.00
```

Automated Means Test Billing Menu
Single Patient Category C Billing Profile

INTRODUCTION

The Single Patient Category C Billing Profile option provides a list of all Means Test/Category C charges within a specified date range for a selected patient.

You will be prompted for patient name, date range, and device. The default at the "Start with DATE" prompt is October 1, 1990. This is the earliest date for which charges can be displayed.

This output displays the date the Category C billing clock began, bill date, bill type (including the treating specialty for inpatient copay charges), the bill number, bill to date (for inpatient charges), amount of each charge, and the total charges for the selected date range.

Due to the brevity of this option, a process chart is not provided.

Automated Means Test Billing Menu
Single Patient Category C Billing Profile

EXAMPLE
Below is an example of what may appear on the screen while using this option followed by a sample output. User responses are shown in boldface type.

```
Select PATIENT NAME: WARREN,SCOTT      01-01-55     112321110     NSC VETERAN
Start with DATE: OCT 01, 1990// 2/26/91  (FEB 26, 1991)
Go to DATE: FEB 26, 1992// <RET> (FEB 26, 1992)
DEVICE: HOME// A137   HP LASER    RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

```
           Category C Billing Profile for WARREN,SCOTT  112-32-1110
From 02/26/91 through 02/26/92        FEB 10, 1994@13:56              Page: 1
BILL DATE   BILL TYPE                        BILL #   BILL TO   TOT CHARGE
-------------------------------------------------------------------------------

04/28/91    Begin Category C Billing Clock
04/28/91      OPT COPAYMENT                  L10038                  $26.00
09/07/91      INPT PER DIEM                  L10085   09/08/91       $20.00
09/07/91      INPT CO-PAY (NEU)              L10084   09/08/91      $628.00
02/10/92      OPT COPAYMENT                  L10038                  $30.00
02/24/92      OPT COPAYMENT                  L10038                  $30.00
                                                                   ----------
                                                                     $774.00
```

Automated Means Test Billing Menu
Disposition Special Inpatient Billing Cases

INTRODUCTION

The Disposition Special Inpatient Billing Cases option is used to enter the reason for not billing inpatient billing cases for veterans whose care is related to their exposure to Agent Orange, ionizing radiation, or environmental contaminants. This option can also be used to edit the reason on cases that have already been dispositioned.

Inpatient bills created for veterans who claim exposure to Agent Orange, ionizing radiation, or environmental contaminants are automatically placed on hold. Once the veteran's treatment has been completed and s/he is discharged, a determination needs to be made if in fact the care rendered was related to the claimed exposure. If the case was not related, charges will have to be entered through the Cancel/Edit/Add Patient Charges option and passed to Accounts Receivable for billing. If the care was related, the patient will not be billed and the case will be dispositioned after the reason for not billing is entered through this option.

You will be prompted for the patient name. The following information will be displayed for the case record: patient name, type, admission date, discharge date, care related to exposure (yes/no), case dispositioned (yes/no), date record last edited, and edited by. You will then be prompted for the reason the case was not billed. This is a free text field allowing up to 80 characters.

Due to the brevity of this option, a process chart has not been provided.

Automated Means Test Billing Menu
Disposition Special Inpatient Billing Cases

EXAMPLE
The following is an example of what may appear on your screen while using the Disposition Special Inpatient Billing Cases option. User responses appear in boldface type.

```
Select Automated Means Test Billing Menu Option: SPID  Disposition Special
Inpatient Billing Cases

This option is used to disposition case records for special (AO/IR/EC)
inpatient episodes of care which are not to be billed.  After identifying the
case, please enter the reason (up to 80 characters) for non-billing.

Select PATIENT: DERDERIAN, TERRY L       12-13-48     022998888     NO     NSC
VETERAN           Adm: SEP 20, 1993@10:10     AGENT ORANGE

-------------------------------------------------------------------------------
 Pt. Name: DERDERIAN,TERRY L  (8888)   Care related to AO: YES
     Type: AGENT ORANGE                Case Dispositioned: NO
 Adm Date: 09/20/93 10:10 pm             Date Last Edited: 10/14/93 4:43 pm
Disc Date: 10/06/93 2:25 pm                Last Edited By: ANDERSON,JOHN
-------------------------------------------------------------------------------
REASON FOR NON-BILLING: TREATMENT RELATED TO AO EXPOSURE

This case record will be dispositioned.
```

Automated Means Test Billing Menu
List Special Inpatient Billing Cases

INTRODUCTION

The List Special Inpatient Billing Cases option is used to provide a listing of all special inpatient billing cases, both dispositioned and undispositioned. Special inpatient billing cases are those where the veteran has claimed his need for treatment is related to exposure to Agent Orange, ionizing radiation, or environmental contaminants.

Inpatient care for NSC Category C veterans who claim exposure to Agent Orange, ionizing radiation, or environmental contaminants is not automatically billed. Once the veteran's treatment has been completed and s/he is discharged, a determination needs to be made if in fact the care rendered was related to the claimed exposure. If the care was related, the patient should not be billed and the case should be dispositioned through the Disposition Special Inpatient Billing Cases option. If the case was not related to exposure, charges will have to be entered manually through the Cancel/Edit/Add Patient Charges option and passed to Accounts Receivable for billing. If the case is billed, the system will automatically disposition the special case.

The following information may be displayed for each case record on the output: patient name, type, admission date, discharge date, care related to exposure (yes/no), case dispositioned (yes/no), date record last edited, and edited by.

The only prompts are for device. Due to the brevity of this option, a process chart has not been provided.

Automated Means Test Billing Menu
List Special Inpatient Billing Cases

EXAMPLE
The following is an example of what may appear on your screen while using the List Special Inpatient Billing Cases option followed by an example of the output. User responses appear in boldface type.

```
Select Automated Means Test Billing Menu Option: spil  List Special Inpatient
Billing Cases

This report will print out all special inpatient billing cases.

DEVICE: HOME// A200       RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW// <RET>   (OCT 20, 1993@09:06:37)

This job has been queued.  The task number is 12284.
```

```
                    LIST ALL SPECIAL INPATIENT BILLING CASES
                                                                  Page: 1
                                                            Run Date: 10/20/93
--------------------------------------------------------------------------------
 Pt. Name: DERDERIAN,TONY T  (8888)    Care related to EC: NO
     Type: ENV CONTAMINANT             Case Dispositioned: YES
 Adm Date: 11/17/93 2:23 pm              Date Last Edited: 11/22/93 10:04 am
Disc Date: 11/22/93 9:52 am                Last Edited By: DERDERIAN,JOHN
--------------------------------------------------------------------------------
 Charges Billed:
     INPT COPAY (MED) NEW          11/17/93   11/17/93   $676   BILLED
     INPT PER DIEM NEW             11/17/93   11/21/93   $40    BILLED
--------------------------------------------------------------------------------



--------------------------------------------------------------------------------
 Pt. Name: VILLANOVA,JOSE  (1250)      Care related to AO: YES
     Type: AGENT ORANGE                Case Dispositioned: YES
 Adm Date: 10/03/93 10:10 pm             Date Last Edited: 10/20/93 7:46 am
Disc Date: 10/06/93 2:25 pm                Last Edited By: BAILEY,JESSICA
--------------------------------------------------------------------------------
 Reason for Non-Billing:
TREATMENT FOR AGENT ORANGE
--------------------------------------------------------------------------------
```

Patient Billing Reports Menu
Print Check-off Sheet for Appointments

INTRODUCTION

The Print Check-off Sheet for Appointments option allows you to print Ambulatory Surgery Check-Off Sheets by patient name or clinic for a specified appointment date. The intent of the check-off sheet is to assist in the billing for BASC procedures. The applicable CPT code(s) for ambulatory surgical procedures may be checked off by the physician and forwarded to billing for processing.

The check-off sheet produced by this option provides some additional patient information that the generic check-off sheet produced by the Check-off Sheet Print option doesn't include. Means Test eligibility, service connected disabilities, and all active insurance carriers are provided.

Appointments must be in clinics that have been assigned to a check-off sheet through the Build CPT Check-off Sheet option. Appointment check-off sheets cannot be printed for appointments that are NO SHOW or CANCELLED.

If you select the appointment date by clinic, the check-off sheets may be sorted by clinic or terminal digit, and one, many or all divisions and clinics may be included. If you select by patient name, all clinic appointments for that patient for the specified appointment date will be displayed for selection.

This output requires a 132 column margin width.

The chart beginning on the following page shows the prompts and steps involved in using this option.

Patient Billing Reports Menu
Print Check-off Sheet for Appointments

PROCESS

The following chart shows the prompts and steps involved in using the Print Check-off Sheet for Appointments option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Print Appointment Check-Off Sheets Select one of the following: P Patient Name C Clinic Select Appointment by: Clinic//	.<RET> or C to select the appointment by clinic .P to select by patient .up-arrow <^>	2 3 10
2	Sort sheets by: (C/T): Clinic//	.<RET> or C to sort check-off sheets by clinic and patient name .T to sort by terminal digit	3 3
3	Appointment DATE: {date}//	.<RET> to accept default .other date	4 4
	After the following message is displayed, you will proceed to Step 5 if you chose to select the appointment by clinic and Step 7 if you chose to select the appointment by patient name.		
4	Only Clinics and Patients with Appointments on this Date will be allowed. Appointments must be in Clinics that have a Check-Off Sheet, to be chosen.		5 or 7
	If a division is entered at this step, you will be prompted to select another division until a <RET> is entered.		
5	Select division: ALL//	.<RET> to accept default .a specific division	6 5

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	If a clinic name is entered at this step, you will be prompted to select another clinic until a <RET> is entered.		
6	Select clinic: ALL//	.<RET> to accept default	9
		.a specific clinic	6
7	Select PATIENT NAME:	.patient name	8
		.<RET>	9
	An appointment profile for the selected patient will be displayed providing the clinic, appointment date/time, and appointment type.		
8	Select Appointments: (#-#):	.corresponding number of the appt. you wish to include	7
		.<RET> or up-arrow <^>	7
9	You will be prompted for a device at this step. This report requires a 132 column margin width.		10
10	Return to the menu.		

Patient Billing Reports Menu
Print Check-off Sheet for Appointments

EXAMPLE
The following is an example of what may appear on your screen while using the Print Check-off Sheet for Appointments option followed by a sample of one of the check-off sheets that can be printed. User responses are shown in boldface type.

```
                    Print Appointment Check-Off Sheets


     Select one of the following:

          P         Patient Name
          C         Clinic

Select Appointment by: Clinic// <RET>
Sort sheets by:  (C/T): Clinic// Terminal Digits
Appointment DATE: APR 2,1992// <RET> (APR 02, 1992)

Only Clinics and Patients with Appointments on this Date will be allowed.
Appointments must be in Clinics that have a Check-Off Sheet, to be chosen.


Select division: ALL// <RET>
Select clinic: ALL// DERMATOLOGY
Select another clinic: <RET>
This report requires a 132 column printer for the CPT list to print.
OUTPUT DEVICE: HOME// A137      HALLWAY LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

EXAMPLE, cont.

AMBULATORY SURGERY CHECK-OFF SHEET INS

Patient Name: KAGAN,PETER
Patient Id: 258-74-1236
Clinic: DERMATOLOGY
Appointment Date/Time: APR 2,1992@09:00
Appointment Type: REGULAR

Means Test: MEANS TEST NOT REQUIRED
Last Means Test: AUG 25,1988
Primary Eligibility: SERVICE CONNECTED 50% to 100%
Service Connected: 50%

Insurance: AETNA
SC Disabilities: 1 KNEE PROSTHESIS 40%
2 MIGRAINE HEADACHES 10%

EKG ( ) LAB ( ) X-RAY ( )

Visit for SC condition: 1, 2
Diagnosis:
Signature:

CPT Codes for DERMATOLOGY

	REMOVAL OF SKIN LESION, TRUNK, ARMS, OR LEGS		
11400	benign 0.5cm or less		( )
11600	malig. 0.5cm or less		( )
11401	benign .06 to 1.0cm		( )
11601	malig. 0.6 to 1.0cm		( )
11402	benign 1.1 to 2.0cm		( )
11602	malig. 1.1 to 2.0cm		( )
11606	benign over 4.0cm		( )
11643	malig. 2.1 to 4.0cm		( )
11644	malig 3.1 to 4.0cm		( )

	REMOVAL OF SKIN LESION, SCALP, NECK, HANDS		
11420	benign 0.5cm or less		( )
11620	malig. .05cm or less		( )
11421	benign .06 to 1.0cm		( )
11621	malig. 0.6 to 1.0 cm		( )
11422	benign 1.1 to 20.cm		( )
11622	malig. 1.1 to 2.0cm		( )
11426	benign over 4.0cm	306.24	( )

	REMOVAL OF SKIN LESION, FACE, EARS, EYELIDS		
11440	benign 0.5cm or less		( )
11640	malig. 0.5cm or less		( )
11441	benign .06 to 1.0cm		( )
11641	malig 0.6 to 1.0cm		( )
11442	benign 1.1 to 2cm		( )
11642	malig 1.1 to 2cm		( )
11446	benign over 4.0cm	306.24	( )
11646	malig over 4.0cm		( )

	MISCELLANEOUS		
40654	repair lip	306.24	( )
11000	biopsy of lesion	666.40	( )
11101	biopsy of additional lesion		( )
11200	removal of skin (15)		( )
11201	removal of skin (over 15)		( )
11730	removal of plate	228.80	( )
12011	repair superficial wound		( )
17000	destruction of face lesion		( )
17001	destruction of face lesions 2&3		( )
17002	destruction of face lesions, over 3		( )

	REMOVAL OF TUMOR		
21555	neck/chest		( )
23075	shoulder		( )
24075	upper arm/elbow		( )
25075	forearm/wrist		( )
26115	hand/finger		( )
27618	lower leg		( )
28043	foot		( )

	DRAIN		
10003	sebaceous cyst		( )
10101	infected nail (s)		( )
10141	hematoma	306.24	( )

	CLEANSING		
11000	surgical of skin	666.40	( )
11001	each add 10%		( )
11042	debridement skin subq	306.24	( )

	TRIM		
11050	skin lesion (1)		( )
11051	skin lesion (2-4)		( )
11052	skin lesion (over 4)		( )

	REMOVAL		
11731	second nail plate	306.24	( )
11750	nail bed	352.00	( )
11752	nail bed/fingertip		( )

	CLOSURE		
12020	split wound (simple)	666.40	( )
12021	split wound (packing)	685.52	( )

Patient Billing Reports Menu
Patient Currently Cont. Hospitalized since 1986

INTRODUCTION This option allows you to print a list (from the IB CONTINUOUS PATIENT file) of current inpatients continuously hospitalized at the same level of care since 1986. This report can be used to verify that all continuous patients are correctly identified. The margin width for this report is 132 columns.

Patients continuously hospitalized since 7/1/86 are exempt from the Medicare deductible copayments, but may still be subject to per diem charges. Facilities are authorized to charge inpatients a per diem charge of $10.00 a day for each day of inpatient care or $5.00 for each day of NHCU care.

Due to the brevity of this option, no process chart is provided.

Patient Billing Reports Menu
Patient Currently Cont. Hospitalized since 1986

EXAMPLE
The following is an example of what might appear on your screen while using the Patient Currently Cont. Hospitalized since 1986 option, followed by a sample output. User responses are shown in boldface type.

```
Margin width of this report is 132 columns

DEVICE: HOME// A137  Laser    RIGHT MARGIN: 132// <RET>
```

```
APR 28,1992        ***Patients Continuously Hospitalized Since July 1, 1986***         PAGE 1

Patient NAME           Pt-Id         Ward Location    Last Means  Means Test     Eligibility
                                                      Test Date   Status
=============================================================================================
ADAMS,STEPHEN          098-57-4321   4D(NHCU)                                    NSC
KAGAN,PETER            033-32-3245   4A(NHCU)         04/02/90    CATEGORY C     NSC
MCBRIDE,WILLIAM        323-23-2327   4B(NHCU)         02/18/92    CATEGORY C     NSC
ROURKE,GAVIN           434-34-3435   4B(NHCU)         02/18/92    CATEGORY C     NSC
```

Patient Billing Reports Menu
Print IB Actions by Date

INTRODUCTION

The Print IB Actions by Date option provides a list of the Integrated Billing actions for a specified date range. Although totals are included, this output should not be used for statistical reporting. The Statistical Report option is provided for that purpose.

This output can be sorted by a specified field. <??> can be entered for a list of appropriate fields for selection and additional commands which may be used to customize your report. If you choose to sort by a certain field, you will be prompted to enter a range for that field. If you accept the default of FIRST, the system will assume you want to include first to last.

Due to the brevity of this option, no process chart is provided.

Patient Billing Reports Menu
Print IB Actions by Date

EXAMPLE
The following is an example of what may appear on your screen while using the Print IB Actions by Date option, followed by a sample output. User responses are shown in boldface type.

```
Print IB Action Entries by Date Added

** Please note that this output requires 132 columns **

START WITH DATE ENTRY ADDED: FIRST// 4/4/91
GO TO DATE ENTRY ADDED: LAST// 4/5/91
  WITHIN DATE ENTRY ADDED, SORT BY: +STATUS
  START WITH STATUS: FIRST// <RET>
DEVICE: A137   HALLWAY HP LASER     RIGHT MARGIN: 132// <RET>

DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

```
INTEGRATED BILLING ACTION LIST                                                  APR 19,1991  10:34    PAGE 1
PATIENT        REF. NO  TYPE             STATUS     DATE ADDED   UNITS    CHARGE  BRIEF DESCRIPTION     CHARGE ID
-------------------------------------------------------------------------------------------------------------------

COOPER,DAVE    500283   SC RX COPAY NEW   BILLED     APR  5,1991      1      2.00  322B-RANITIDINE 15-1  500-M10027
COOPER,DAVE    500285   SC RX COPAY NEW   BILLED     APR  5,1991      1      2.00  230A-AMPICILLIN 50-1  500-M10033
ADDISON,JOHN   500286   NSC RX COPAY NEW  BILLED     APR  5,1991      1      2.00  193B-BELLADONNA TI-1  500-M10033
GREEN,MICHAEL  500287   SC RX COPAY NEW   BILLED     APR  5,1991      3      6.00  357-BENZTROPINE 1M-3  500-M10009
               ---------                                              -----  --------
SUBTOTAL                                                                  6     12.00
SUBCOUNT       4
DALY,THOMAS    500263   SC RX COPAY NEW   CANCELLED  APR  4,1991      1      2.00  352-AMPICILLIN 25, 1  500-M10027
COOPER,DAVE    500264   SC RX COPAY NEW   CANCELLED  APR  4,1991      1      2.00  286A-CIMETIDINE 3, 1  500-M10027
JAMES,MICHAEL  500275   SC RX COPAY NEW   CANCELLED  APR  4,1991      3      6.00  167A-ACETAMINOPHE, 3  500-M10009
               ---------                                              -----  --------
SUBTOTAL                                                                  5     10.00
SUBCOUNT       3
               ---------                                              -----  --------
TOTAL                                                                    11     22.00
COUNT          7
```

Patient Billing Reports Menu
Employer Report

INTRODUCTION

The Employer Report option is used to provide a listing of patients and spouses' employers for patients without active insurance which can be used by billing clerks to confirm insurance coverage with those employers.

The report is sorted by employer name and is run for a selected date range. You can run the report for inpatient admissions or outpatient visits. One, many, or all divisions can be chosen. For outpatients, patients are included on the report if they have an event within the specified date range, do not have active insurance on the event date, and the patient's or spouse's employment status is one of the following.

EMPLOYED FULL TIME
EMPLOYED PART TIME
SELF EMPLOYED
RETIRED

Events include admissions for inpatients and scheduled/ unscheduled visits and dispositions that are not APPLICATION WITHOUT EXAM for outpatients.

Deceased veterans do not appear on the report.

The following information may appear on the output: employer name, address, phone number, patient name, SSN, occupation, employment status, home and work phone numbers, primary eligibility, admission date, transaction type, appointment date, and appointment type. Generation of this report requires 132 column margin width.

The process chart on the following page shows the prompts and steps involved in using this option.

Patient Billing Reports Menu
Employer Report

PROCESS
The following chart shows the steps and prompts involved in using the Employer Report option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Beginning Value: +//	.first character of the employer's name	2
		.<-> for patients who indicated they were employed but have no employer on file	3
		.<RET> or <+> for all employers	3
		.up-arrow <^>	8
2	Ending Value: Z//	.first character of employer's name to be used as ending value of the search	3
		.<RET> to accept default	3
3	Select PATIENT TYPE: (INPT/OPT):	.INPT for inpatient movements	5
		.OPT for outpatient visits	4
	If entering individual divisions, "Select another division" will be repeated until a <RET> is entered. Up to 20 divisions can be selected.		
4	Select division: ALL//	.individual division name/number	4
		.<??> for list of divisions	4
		.<RET> to accept default for all divisions	5
		.<RET> (no default)	5
5	START WITH Date:	.admission/visit date to start search	6
6	GO TO Date: ({date} - {date}): TODAY//	.<RET> to accept default of today	7
		.other date to end search	7
7	"Report requires 132 columns."		
	You will be prompted for a device at this step.		8
8	Return to the menu.		

Patient Billing Reports Menu
Employer Report

EXAMPLE

The following is an example of what may appear on your screen while using the Employer Report option followed by an example of the output. User responses appear in boldface type.

```
Beginning Value: +// <RET>
Select PATIENT TYPE:  (INPT/OPT): INPT
START WITH Date: 6 1 93  (JUN 01, 1993)
GO TO Date:  (6/1/93 - 10/21/93): TODAY// <RET>   (OCT 21, 1993)

Report requires 132 columns.
OUTPUT DEVICE: HOME// A200        RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y   (YES)

Requested Start Time: NOW// <RET>   (OCT 21, 1993@10:37:30)
```

```
EMPLOYER REPORT FOR INPATIENT ADMISSIONS JUN 1,1993 - OCT 21,1993          OCT 21, 1993  11:15        PAGE 1
-------------------------------------------------------------------------------------------------------------------

BABY BOOMERS                                4444 E KINDER RD, ALBANY, NEW YORK 12443

   Patient: MARRY,MICHAEL                   009-89-7890    NSC    JUN 10, 1993   ADMISSION      Home:
   Employed: Spouse:  MARRY,BEATRICE                       DAY CARE              RETIRED

-------------------------------------------------------------------------------------------------------------------

HERTY'S GERTY'S       518-2738738           5678 SOUTH ST, TROY, NEW YORK 12345

   Patient: REMSEN,CORNEL                   209-83-0983    NSC    JUN 10, 1993   ADMISSION      Home: 518-3939393
   Employed: Patient: REMSEN,CORNEL         209-83-0983    HERTYGERTYMAN         FULL TIME      Work: 518-3738383

-------------------------------------------------------------------------------------------------------------------

IBM CORPORATION       345-781-1234          1 IBM LANE, OSSINING, NEW YORK 10045

   Patient: STEWART,PAUL                    405-10-2120    SC 1   JUN 02, 1993   ADMISSION      Home: 345-7812332
   Employed: Patient: STEWART,PAUL          405-10-2120    COMPUTER OPERATOR     FULL TIME      Work: 345-7811234

-------------------------------------------------------------------------------------------------------------------
```

Patient Billing Reports Menu
Episode of Care Bill List

INTRODUCTION

The Episode of Care Bill List option is used to list all bills related to an episode of care. The bills are listed by event date in reverse date order. The bill number, rate type, bill classification, event date, statement from and to dates, bill status, and time frame of bill will be displayed for each bill on the list.

You may enter the bill number, event date, or patient name at the bill selection prompt. If the event date or patient name is entered, all bills with that event date or for that patient will be listed for selection. Only patients with bills on file may be entered.

The output produced by this option must be generated at a 132 column margin width.

Due to the brevity of this option, a process chart has not been provided.

Patient Billing Reports Menu
Episode of Care Bill List

EXAMPLE

The following is an example of what might appear on the screen while using the Episode of Care Bill List option. User responses are shown in boldface type. An example of the output generated by this option is shown below.

```
Select BILL/CLAIMS BILL NUMBER:  900071       KILLIAN,ARTHUR     02-13-87
MEANS TEST/CAT. C     PRINTED

DEVICE: HOME//  A126          RIGHT MARGIN 132//  <RET>   (JUL  5,1990@08:16)
DO YOU WANT YOUR OUTPUT QUEUED? NO//  YES

Request Start Time: NOW//  <RET>

REQUEST QUEUED!
```

```
LIST OF ALL BILLS FOR AN EPISODE OF CARE                              JUL 5,1990@08:16   PAGE 1
FOR PATIENT: KILLIAN,ARTHUR   EVENT DATE: FEB 13,1987
                                                          STATEMENT    STATEMENT
BILL NO.   RATE TYPE           CLASSIFICATION  EVENT DATE  FROM DATE    TO DATE  STATUS      TIMEFRAME OF BILL
-------------------------------------------------------------------------------------------------------------
900071     MEANS TEST/CAT. C   INPATIENT       02/13/87    02/13/87    03/12/87  PRINTED     INTERIM - CONTINUING
    PAYOR: Patient - KILLIAN,ARTHUR
000491     REIMBURSABLE INS.   INPATIENT       02/13/87    03/13/87    04/12/87  PRINTED     INTERIM - CONTINUING
    PAYOR: Insurance Co. - ABC INSURANCE
000543     REIMBURSABLE INS.   INPATIENT       02/13/87    04/13/87    04/30/87  AUTHORIZED  INTERIM - LAST
    PAYOR: Insurance Co. - ABC INSURANCE
```

Patient Billing Reports Menu
Estimate Category C Charges for an Admission

INTRODUCTION

This option is used to estimate the Means Test/Category C charges for an episode of hospital or nursing home care for a proposed length of stay. It may be used to answer patient inquiries pertaining to estimated charges to be billed for an inpatient stay.

The report will indicate whether or not the patient has an active billing clock, the start date, and the number of inpatient days of care within that clock.

If a patient has an active clock and has already been charged a copayment for the current 90 days of inpatient care, the amount billed is shown. Also provided is the amount of copay and per diem that would be billed for this proposed episode of care. For further information, please refer to the data supplement at the end of this option documentation.

The chart on the following page shows the prompts and steps involved in using this option.

Patient Billing Reports Menu
Estimate Category C Charges for an Admission

PROCESS

The following chart shows the prompts and steps involved in using the Estimate Category C Charges for an Admission option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select PATIENT NAME:	.patient name or SSN	2
		.<RET> or up-arrow <^>	7
	If the selected patient is currently an inpatient and Category C charges have already been calculated for this stay, the following message will appear and you will proceed to Step 4. Otherwise you will proceed to Step 3.		
2	Please note that this patient was admitted on {DATE} and Category C charges have been calculated through {DATE}.		4
3	Proposed ADMISSION Date:	.the date the estimated length of stay will begin (if the year is omitted, the system assumes a date in the past)	4
4	Proposed DISCHARGE Date:	.the date the estimated length of stay will end (if the year is omitted, the system uses the current year)	5
	This step will not appear if the patient is currently an inpatient and Category C charges have already been calculated for this stay.		
5	Anticipated Facility Treating Specialty:	.the treating specialty for this anticipated episode of care	6
		.<??> for a list	5
6	You will be prompted for a device at this prompt.		7
7	Return to the menu.		

Patient Billing Reports Menu
Estimate Category C Charges for an Admission

EXAMPLE
The following is an example of what may appear on the screen while using the Estimate Category C Charges for an Admission option followed by a sample output. User responses are shown in boldface type.

```
Select PATIENT NAME:    KAGAN,PETER    07-07-40   442121211     NSC VETERAN
Proposed ADMISSION Date: T  (FEB 25, 1992)
Proposed DISCHARGE Date: T+4  (FEB 29, 1992)
Anticipated Facility Treating Specialty:  OPHTHALMOLOGY    OPHTHALMOLOGY   53
DEVICE: HOME//  A137  HP LASER    RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)



Estimated Category C Inpatient Charges for KAGAN,PETER

Charges will be estimated from 02/25/92 through 02/29/92.
** THIS PATIENT HAS AN ACTIVE BILLING CLOCK **
      Clock date: 12/20/91   Days of inpatient care within clock:   2
      Copayments made for current 90 days of inpatient care:  $628.00
COPAYMENT CHARGES for SURGICAL CARE
-------------------------------------------------------------------------------
   Billing Dates           Inpt. Days        Clock Days
  From         To         1st     Last      1st     Last          Charge
-------------------------------------------------------------------------------
02/20/92    02/25/92        1        1       72       72          $24 00
                                                                ----------
                                                                    $24 00
PER DIEM CHARGES for HOSPITAL CARE
-------------------------------------------------------------------------------
02/25/92    02/28/92      4 days  @ $10.00/day                      $40.00
                                                                ----------
                                    Total Estimated Charges:        $64.00
```

Patient Billing Reports Menu
Estimate Category C Charges for an Admission

DATA SUPPLEMENT

DATA ELEMENT	**DESCRIPTION**
CLOCK DATE	Date the current billing clock began for this patient.
DAYS OF INPATIENT CARE WITHIN CLOCK	Number of days of inpatient or nursing home care within the current billing clock.
COPAYMENTS MADE FOR CURRENT 90 DAYS OF INPATIENT CARE	Total amount of copayment made for the current 90 days of inpatient care for the current billing clock.
COPAYMENT CHARGES FOR {type of care}	Amount of the copayment charge for this proposed inpatient stay. The copayment charge differs depending on the type of inpatient care; however, it will not exceed the current Medicare deductible. Once the deductible is met, the patient is covered for 90 days of hospital care. For the second, third, and fourth 90 days of hospital care, the copayment charge is half of the current Medicaid deductible. For other than hospital care (i.e., NHCU), the full deductible applies for each 90 days of care.
BILLING DATES {FROM/TO}	Date(s) the copayment occurred. If the proposed episode of care was for a total of five days (2/1/92 - 2/5/92), but the deductible was met the first day; the billing dates (from and to) would reflect the first day only (2/1/92).

DATA SUPPLEMENT, cont.

DATA ELEMENT	DESCRIPTION
INPATIENT DAYS {1st/Last}	On which days of the current 90 days of inpatient care this copayment occurred. If the patient previously had two days of inpatient care in the current 90 days and the deductible was met the first day of this proposed episode of care, the "inpatient days" would reflect day three as the days (1st and last) this copayment was incurred.
CLOCK DAYS {1st/Last}	On which days of the current billing clock this copayment was incurred. If the current billing clock began on 2/1/92 and the copayment for this proposed episode of care was incurred on 2/15/92 and 2/16/92, the "clock days" would reflect day 15 for the 1st and day 16 for the last.
CHARGE	Amount of the copayment or per diem charge for this proposed episode of care.
PER DIEM CHARGES FOR {type of care}	A daily charge for the inpatient stay. No charge is incurred for the day of discharge (i.e., if the proposed inpatient stay is 2/1/92 thru 2/5/92 and the per diem rate is $10.00, the total per diem charge would be $40.00).
TOTAL ESTIMATED CHARGES	Total of the copayment and the per diem charges for the proposed inpatient stay.

Patient Billing Reports Menu
Outpatient/Registration Events Report

INTRODUCTION

In Integrated Billing V. 1.5, the Outpatient/Registration Events Report was used primarily to list potentially billable outpatient activity (for Category C veterans) for the purpose of billing charges that were not automatically billable by the system. As IB V. 2.0 completes the automation of Means Test billing for all outpatient activity, this report becomes a validation tool.

This option lists all episodes of outpatient care for Category C veterans within a user specified date range; appointments, stop codes, and registrations. For each visit, the clinic, appointment time, type, and status are provided. Clinics with a default type of "research" are flagged on the report to assist sites in determining if regular appointments are being scheduled in clinics where the primary intent is research. For each patient listed, the report indicates whether the patient has claimed exposure to Agent Orange, ionizing radiation, or environmental contaminants and whether the patient has active insurance. If exposure is claimed, the responses to the Classification questions answered during the checkout process are displayed. Any charges associated with the episode of care are included.

A separate page will print for each date within the date range; therefore, you may wish to limit the date range selected. You may also wish to run this report during off hours, as it may be quite time consuming.

Due to the brevity of this option, no process chart is provided.

Patient Billing Reports Menu
Outpatient/Registration Events Report

EXAMPLE
The following is an example of what might appear on your screen while using the Outpatient/Registration Events Report option followed by a sample output. User responses appear in boldface type.

```
Start with DATE: 9/1  (SEP 01, 1993)
Go to DATE: t  (SEP 02, 1993)
DEVICE: HOME// A138   LASER    RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW//T@1700  (SEP 13, 1993@17:00:00)

Request Queued!
```

```
          Category C Outpatient and Registration Activity for 09/01/93
                                Printed: 09/13/93                    Page: 1

Patient/Event       Time  Clinic/Stop       Appt.Type          (Status)


ABBOTT,JOHN A. A0101P    [AO]    **Insured**
     CLINIC APPT    12:00 PODIATRY          REGULAR            NO ACTION TAKEN


DERDERIAN,TERRY L D1250P    [AO]    **Insured**
     CLINIC APPT    09:00 GEN. MEDICAL      REGULAR            CHECKED OUT
      Care related to AO? YES

     STOP CODE      09:00 EKG               REGULAR
                    09:00 LABORATORY        REGULAR
```

```
          Category C Outpatient and Registration Activity for 09/02/93
                                Printed: 09/13/93                    Page: 2

Patient/Event       Time  Clinic/Stop       Appt.Type          (Status)


No Outpatient activity recorded for Category C patients on 09/02/93.
```

Patient Billing Reports Menu
Held Charges Report

INTRODUCTION

The Held Charges Report provides you with a list of all charges with a status of ON HOLD. Charges for Category C patients with insurance are placed on hold until the patient's insurance company bill is resolved. When payment is received from the insurance carrier, the status of the charge is updated through the Release Charges 'On Hold' option.

This report may be used to insure that there is an insurance bill established for each charge on hold, and to identify charges that should be released when payments are received from insurance carriers.

The following information is provided: patient name and ID, action ID, type of charge, bill number, the from and to dates, and the corresponding charge. If there is a corresponding insurance bill, the bill number, A/R status, charge amount, and amount paid are also provided.

Due to the brevity of this option, no process chart is provided.

Patient Billing Reports Menu
Held Charges Report

EXAMPLE
The following example shows what might appear on your screen while using this option followed by a sample output. User responses are shown in boldface type.

```
*** Margin width of this output is 132 ***
*** This output should be queued ***
DEVICE: HOME// A137    HALLWAY HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW// T@1800 (MAY 26, 1992@18:00:00)
REQUEST QUEUED TASK=5687
```

CATEGORY C CHARGES ON HOLD — MAY 26,1992

PAGE 1

HELD CHARGES								CORRESPONDING THIRD PARTY BILLS			
Name	Pt.ID	ActionID	Type	Bill#	From	To	Charge	Bill#	AR-Status	Charge	Paid
BAKER,DAN	0540	500942	OPT	L10220	03/01/92	03/11/92	30.00	L10209	NEW BILL	148.00	0.00
		500948	INPT	L10233	03/11/92	03/14/92	652.00				
		500954	OPT	L10229	03/11/92	03/11/92	30.00				
CANNEL,STAN	4949	5002661	OPT	L10305	05/08/92	05/08/92	30.00				
COOPER,ROBERT	1232	5001488	OPT	L10259	04/07/92	04/07/92	30.00				
		5001512	OPT	L10259	04/03/92	04/03/92	30.00	L10342	NEW BILL	296.00	0.00
DAVIS,JOHN	3035	5002673	INPT	L10304	05/19/92	05/19/92	238.00				
LOMBARDO,VITO	0823	5001449	INPT	L10178	03/01/92	03/01/92	652.00	L10235	NEW BILL	5736.00	0.00
STEINER,JOHN	3434	5001476	INPT	L10261	04/13/92	04/16/92	652.00				
WARREN,JAMES	3232	5001024	OPT	L10121	03/23/92	03/23/92	30.00	L10329	NEW BILL	740.00	0.00
		5001025	OPT	L10121	03/23/92	03/23/92	30.00				
		5001026	OPT	L10121	03/23/92	03/23/92	30.00				
		5001029	OPT	L10121	03/23/92	03/23/92	30.00				
		5001030	OPT	L10121	03/23/92	03/23/92	30.00				

Patient Billing Reports Menu
Patient Billing Inquiry

INTRODUCTION

The Patient Billing Inquiry option allows you to display/print information on any reimbursable insurance bill, Pharmacy Copay, or Means Test bill. The information provided differs depending on the bill type.

For reimbursable insurance bills, the information provided includes bill status, rate type, reason cancelled (if applicable), admission date (for inpatients), all outpatient visits (for outpatients), charges, amount paid, statement to and from dates, each action that was taken on that bill, and the user who performed it. If you choose to view the full inquiry, address information from the PATIENT file (#2) and the bill is also provided.

The information provided in a brief inquiry for Pharmacy Copay charges includes date of charge, type of charge (syntax: patient eligibility - action type - status), brief description (syntax: prescription # - drug name - # of units), amount of charge or credit, and an explanation of any charge removed, if applicable. A full inquiry, in addition to the information provided in the brief inquiry, provides information from the PRESCRIPTION file (#52), as well as address information on the patient.

The display/output for Means Test bills is very similar to the brief inquiry for Pharmacy Copay. It includes the date of charge, charge type, brief description, units, and amount of charge. A full inquiry also includes address information on the patient.

The medication copayment exemption status and reason are displayed for medication copayment and Means Test bills.

Due to the brevity of this option, no process chart is provided.

Patient Billing Reports Menu
Patient Billing Inquiry

EXAMPLE
The following is an example of what might appear on the screen while using the Patient Billing Inquiry option. User responses are shown in boldface type. Examples are provided on the following page.

```
Select CHARGE ID or PATIENT NAME: L10008  500-L10008       C (MEANS TEST)
02-07-92    ALLEN,JOHN A     OPEN  $628.00
(B)rief or (F)ull Inquiry: B// FULL

Output Device: HOME// A137  LASER PRINTER   RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)

Select CHARGE ID or PATIENT NAME:
```

EXAMPLE, cont.

EXAMPLE 1 - Full inquiry for a reimbursable insurance bill.

```
ALLEN,JOHN A    442-12-1211       500-000303    FEB 19, 1992@14:17     PAGE: 1
================================================================================
Bill Status    : PRINTED - RECORD IS UNEDITABLE
Rate Type      : REIMBURSABLE INSURANCE
Form Type      : UB-82

Op Visit dates : APR 14,1992

Charges        :  $148.00
LESS Offset    :   $30.00
Bill Total     :  $118.00

Statement From : APR 14,1992
Statement To   : APR 14,1992

Entered        : APR 15, 1992 by CORCHRAN,EDWARD
First Reviewed : APR 16, 1992 by MIX,SUE
Last Reviewed  : APR 16, 1992 by MIX,SUE
Authorized     : APR 16, 1992 by MIX,SUE
Last Printed   : APR 16, 1992 by HOOPER,GARY
```

```
ALLEN,JOHN A    442-12-1211       500-000303    FEB 19, 1992@14:17     PAGE: 2
================================================================================

*** ADDRESS INFORMATION ***

Patient Address:  117 ALLEN DRIVE
                  COLONIE, NEW YORK
                  518-786-0990

Mailing Address:  AETNA
                  1262 MOONBEAM AVENUE
                  LOS ANGELES, CALIFORNIA   12345

Ins Co. Address:  AETNA
                  1262 MOONBEAM AVENUE
                  LOS ANGELES, CALIFORNIA   12345
                  618-567-5555
```

EXAMPLE, cont.

EXAMPLE 2 - Full inquiry for a Means Test bill.

```
DENNIS,JOHN   436-88-2965          500-L10098   FEB 24, 1992@09:09   PAGE: 1
Medication Copayment Exemption Status: NON-EXEMPT
Patient's income is greater than Copay Income Threshold
================================================================================
FEB 14, 1992   INPT COPAY (MED) NEW  INPT CO-PAY (MED)         1      $200.00
FEB 20, 1992   INPT COPAY (MED) CAN  INPT CO-PAY (MED)         1     ($200.00)
     Charge Removal Reason: MT CHARGE EDITED
                                                                   ------------
                                                                         $0.00
```

```
DENNIS,JOHN   436-88-2965          500-L10098   FEB 24, 1992@09:09   PAGE: 2
Medication Copayment Exemption Status: NON-EXEMPT
Patient's income is greater than Copay Income Threshold
================================================================================

                          *** ADDRESS INFORMATION ***

Patient Address:  28 TURNIPFIELD RD
                  EASTHAM, MASSACHUSETTS
                  508-321-4321
```

EXAMPLE 3 - Brief inquiry for a Pharmacy Copay bill.

```
KAGAN,PETER    442-12-1211         500-M10004   FEB 24, 1992@09:18   PAGE: 1
Medication Copayment Exemption Status: EXEMPT
Patient's income below Copay Income Threshold

DATE           CHARGE TYPE           BRIEF DESCRIPTION        UNITS     CHARGE
================================================================================
MAR 15, 1991   SC RX COPAY NEW       RX#111128-REF 5-ENDU       3        $6.00
MAR 15, 1991   SC RX COPAY NEW       RX#111199 9999-CLONI       4        $8.00
                                                                   ------------
                                                                        $14.00
```

Patient Billing Reports Menu
List all Bills for a Patient

INTRODUCTION

The List all Bills for a Patient option is used to print a list of all bills on file for a selected patient. The patient may be selected by name or social security number.

The bills are listed by date of care in reverse date order. The bill number, date printed, action/rate type, classification, date of care, statement from and to dates, amount collected, status, and time-frame of the bill will be displayed for each bill on the list. Below is a brief explanation of some of these data elements.

Bill Number	If IB action is incomplete, "pending" is displayed. If IB action is converted, this field will be blank.
Date Printed	Date bill generated.
Action/Rate Type	Action for IB actions; rate type for insurance bills.
Date of Care	Admission date for inpatients; opt visit date for outpatients; date medication dispensed for Pharmacy Copay.
Amount Collected	Not applicable to patient bills; amount from Accounts Receivable for insurance bills.
Time frame of Bill	Null if IB action.

You will be prompted for a patient name and whether or not to include Pharmacy Copay charges on the report.

The output produced by this option must be generated at a 132 column margin width.

Due to the brevity of this option, a process chart has not been provided.

Patient Billing Reports Menu
List all Bills for a Patient

EXAMPLE
The following is an example of what might appear on the screen while using the List all Bills for a Patient option. User responses are shown in boldface type. An example of the output generated by this option is shown below.

```
Select PATIENT NAME:  KILLIAN,ARTHUR    09-30-45   123432333      NSC VETERAN
Include Pharmacy Co-Pay charges on this report? NO// YES
You will need a 132 column printer for this report.

DEVICE: HOME//  A126           RIGHT MARGIN 132//  <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO//  YES

Request Start Time: NOW//  <RET>    (MAR 5,1992@08:16)

Request Queued!
```

```
List of all Bills for KILLIAN,ARTHUR                                                    MAR 5,1992@08:16   PAGE 1
BILL      DATE                                          DATE OF    STATEMENT   STATEMENT    AMOUNT
NO.       PRINTED    ACTION/RATE TYPE    CLASSIFICATION    CARE      FROM DATE    TO DATE    COLLECTED   STATUS    TIMEFRAME OF BILL
-------------------------------------------------------------------------------------------------------------------------------
M10053    02/20/92   NSC RX COPAY        PHARMACY COPAY    02/20/92  02/20/92    02/20/92      N/A       BILLED
L10157    02/07/92   NSC RX COPAY        PHARMACY COPAY    02/07/92  02/07/92    02/07/92      N/A       UPDATED
L10063    02/11/92   REIMBURSABLE INS.   OUTPATIENT        01/30/92  01/01/92    01/31/92      0.00      PRINTED   ADMIT-DISCHARGE
```

Patient Billing Reports Menu
Category C Billing Activity List

INTRODUCTION

The Category C Billing Activity List option is used to list all Means Test/Category C charges within a specified date range. The list is alphabetical by patient name.

This output provides the patient name and ID, a brief description, the status and the billing period for the bill, the units (the number of days a charge occurred), and the amount of the charge. For inpatient copay charges, the description includes the treating specialty for the episode of care.

As stated above, the units reflect the number of days a charge occurred. For inpatient copay charges the unit will always be one, even if the patient accrued the charges over a number of days before the Medicare deductible was met.

You will be prompted for a date range and device.

Due to the brevity of this option, a process chart is not provided.

Patient Billing Reports Menu
Category C Billing Activity List

EXAMPLE
Below is an example of what may appear on the screen while using the Category C Billing Activity List option followed by a sample output. User responses are shown in boldface type.

```
Start with DATE: 1/1  (JAN 01, 1992)
Go to DATE: T  (FEB 26, 1992)
DEVICE: HOME// A137   HP LASER    RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

```
Category C Billing Activity List             FEB 26, 1992@09:14:28     Page: 1
Charges from 01/01/92 through 02/26/92
PATIENT/ID        DESCRIPTION       STATUS         FROM       TO   UNITS CHARGE
-------------------------------------------------------------------------------
KAGAN,PETER 2086  INPT PER DIEM     BILLED      01/02/92  01/03/92  2   $20.00
                  INPT COPAY (ALC)  BILLED      01/02/92  01/03/92  1  $476.00
MCBRIDE,NED 8745  OPT COPAY         PENDING A/R 02/11/92  02/11/92  1    $0.00
MOORE,TIM   8761  INPT PER DIEM     BILLED      01/13/92  01/14/92  2   $20.00
                  INPT COPAY (MED)  BILLED      01/13/92  01/14/92  1  $652.00
NELSON,KEN  0978  OPT COPAY         PENDING A/R 02/12/92  02/12/92  1    $0.00
PAUL,JOHN   9065  OPT COPAY         BILLED      02/17/92  02/17/92  1   $30.00
RICH,DAN    1243  OPT COPAY         BILLED      02/13/92  02/13/92  1   $30.00
SIMS,HAROLD 1122  INPT PER DIEM     BILLED      01/13/91  01/18/92  6   $60.00
                  INPT COPAY (MED)  BILLED      01/13/92  01/18/92  1   $24.00
VOIT,RICK   9467  OPT COPAY         BILLED      02/12/92  02/12/92  1   $30.00
```

Patient Billing Reports Menu
Third Party Output Menu
Veterans w/Insurance and Discharges

INTRODUCTION

The Veterans w/Insurance and Discharges option is used to produce a list of all patients who have reimbursable insurance and who were discharged from the medical center during a selected date range. For dates of care prior to 10/1/90, service-connected veterans with insurance who were treated for a non service-connected condition (from the PTF record) will be included on the list. This list may be used to help insure that a bill exists for all billable inpatient episodes of care for that date range.

You may include unbilled patients, previously billed patients, or both on the report. If you choose to print ALL (both unbilled and previously billed), the report is sorted by these two categories. The unbilled patients portion displays the patient ID#, patient name, SSN, eligibility status, date of care (event date), and the patient's insurance companies. The previously billed list displays the same data plus every bill within the selected date range for each patient showing the bill number, bill rate type, statement from and to dates, and the debtor.

The lists are printed in alphabetical order by patient name or numerically by terminal digit (8th and 9th digit of the SSN, then 6th and 7th, etc.). For multidivisional sites, you may print a list for each division.

Depending on the size of your database and the date range selected, this report could be quite lengthy. It is recommended the report be queued to print during non-peak user hours.

The chart beginning on the following page shows the prompts and steps involved in using this option.

Patient Billing Reports Menu
Third Party Output Menu
Veterans w/Insurance and Discharges

PROCESS

The following chart shows the prompts and steps involved in using the Veterans w/Insurance and Discharges option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Start with DATE:	.date with which to begin the report	2
		.<RET> or up-arrow <^>	7
2	Go to DATE:	.date to end report	3
	This prompt will appear only for multidivisional facilities. If a specific division is selected, the prompt will repeat until a <RET> is entered.		
3	Select division: ALL//	.<RET> to accept the default and print a report for all divisions	4
		.specific division	3
		.<??> for a list of divisions	3
4	Select one of the following: 1 UNBILLED 2 BILLED 3 ALL PRINT LISTING: UNBILLED//	.<RET> or 1 for unbilled patients	5
		.2 for previously billed patients	5
		.3 for all	5
5	Sort by (P)atient Name or (T)erminal Digit: P//	.<RET> or Patient to sort alphabetically by patient name	6
		.Terminal Digit to sort numerically by terminal digit	6

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
6	You will be prompted for a device at this step.		
7	Return to the menu.		

Patient Billing Reports Menu
Third Party Output Menu
Veterans w/Insurance and Discharges

EXAMPLE

The following is an example of what might appear on the screen while using this option. User responses are shown in boldface type. A copy of the output is provided below. When generated, the two categories (Unbilled Patients and Previously Billed Patients) will appear on separate pages.

```
Start with DATE: 2/1  (FEB 01, 1992)
Go to DATE: t-1  (FEB 29, 1992)
Select division: ALL// ALBANY
Select another division: <RET>

     Select one of the following:

          1         UNBILLED
          2         BILLED
          3         ALL

PRINT LISTING: UNBILLED// 3  ALL
Sort by (P)atient Name or (T)erminal Digit: P// <RET>   PATIENT NAME

*** Margin width of this output is 132 ***
*** This output should be queued ***

DEVICE: HOME// A137   HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// YES  (YES)

Requested Start Time: NOW//  T@6:00   (MAR 01,1992@06:00)

Request Queued!
```

```
*Veterans with Reimbursable Insurance and INPATIENT Discharges for the period covering FEB 01,1992 through FEB 29,1992
UNBILLED PATIENTS for Division ALBANY                  Printed: MAR 01,1992@06:00              Page: 1
PT ID PATIENT             SSN           ELIGIBILITY       DATE OF DISCHARGE     INSURANCE COMPANIES
=============================================================================================================
4432  ALBER,JOHN          128-10-4432   NON-SERVICE CONN  FEB 20,1992@15:51:15  AETNA

1111  MOORE,DAN           567-11-1111   NON-SERVICE CONN  FEB 19,1992@12:52:51  ALLSTATE

4444  RAY,CHARLES         777-74-4444   NON-SERVICE CONN  FEB 19,1992@14:40:18  NORTHWEST
```

```
*Veterans with Reimbursable Insurance and INPATIENT Discharges for the period covering FEB 01,1992 through FEB 29,1992
PREVIOUSLY BILLED PATIENTS for Division ALBANY           Printed: MAR 01,1992@06:00              Page: 1
PT ID PATIENT             SSN           ELIGIBILITY       DATE OF DISCHARGE     INSURANCE COMPANIES
=============================================================================================================
3232  MATHERS,THEODORE    123-22-3232   NON-SERVICE CONN  FEB 7,1992@13:48:23   AETNA
         L10042    REIM INS-INPT      From: 02/07/92    To: 02/07/92       Debtor: AETNA

9012  PETERS,ROBERT       345-67-9012   NON-SERVICE CONN  FEB 14,1992@13:00     AETNA
         L10030    REIM INS-INPT      From: 02/14/92    To: 02/19/92       Debtor: AETNA

3232  WARNER,ALBERT       123-22-3232   NON-SERVICE CONN  FEB 7,1992@13:48:23   AETNA
         L10042    REIM INS-INPT      From: 02/07/92    To: 02/10/92       Debtor: AETNA
```

Patient Billing Reports Menu
Third Party Output Menu
Veteran Patient Insurance Information

INTRODUCTION

The Veteran Patient Insurance Information option provides insurance information on veteran inpatients. This includes such information as insurance company, insurance number, group number, and insurance expiration date. Medical information is also shown. Dates of admission and discharge and status of the PTF records are provided. The report is broken down by patient, with information on length of stay for each bedsection, diagnoses, and diagnostic codes. The total length of stay is shown with the primary diagnosis.

The form indicates whether or not the policy shown will reimburse VA for the cost of medical care. If the REIMBURSE field of the INSURANCE COMPANY file is set to NO for any of the companies that cover the applicant, an asterisk (*) will be shown next to the insurance company name and the following message will appear.

```
* -  Insurer may not reimburse!!
```

All of this information is used in billing the insurance companies for the cost of the veteran's care.

The report may be sorted sequentially by discharge or admission date. You will be prompted for a date range and device. Depending on the number of applicable admissions and the size of the date range specified, generation of this report could be time-consuming. You may choose to queue the report to print during non-peak user hours.

Due to the brevity of this option, a process chart has not been provided.

Patient Billing Reports Menu
Third Party Output Menu
Veteran Patient Insurance Information

EXAMPLE

Following is an example of what might appear on the screen while using the Veteran Patient Insurance Information option. User responses are shown in boldface type. An example of the output produced by this option is shown below.

```
Sort by Discharge or Admission: D//  <RET>   DISCHARGE
START DATE:  4-19-90   (APR 19, 1990)
  END DATE:  4-20-90   (APR 20, 1990)
DEVICE: HOME//  QUEUE TO PRINT ON
DEVICE: HOME//  WAITING AREA PRINTER             RIGHT MARGIN: 132//  <RET>

Requested Start Time:  NOW//  <RET>    (JAN 11, 1991@0915)

Request Queued!
```

```
THIRD PARTY REIMBURSEMENT                                PRINTED:  JAN 11,1991@0915

GIBSON, CLARK                                  EMPLOYMENT STATUS:  EMPLOYED
(PT ID: 123434332)                                      EMPLOYER:  CANTRELL LUMBER
307 LANGLY BLVD                                      OCCUPATION:  CARPENTER
TOLEDO, OHIO   55555

INSURANCE TYPE            INSURANCE #            GROUP #       EXPIRES        HOLDER
--------- ----            --------- -            ----- -       -------        ------

AETNA                     123                    887           01/01/93      VETERAN
*PRUDENTIAL               64098                  21            12/31/91      VETERAN
                  * - Insurer may not reimburse!!


Admitted:  APR 9,1990@14:00               Discharged:  APR 19,1990@13:39
PTF Record not closed


DATE                LOS BEDSECTION      LOS     DIAGNOSES
----                --------------      ----    ---------
APR 10,1990@11:29   OPHTHALMOLOGY         1    334.4 (CORNEAL ABRASION)
APR 11,1990@10:10   UROLOGY               1    778.0 (URINARY TRACT INFECTION,
                                                      UNSPEC.)
APR 19,1990@13:39   CARDIOLOGY            8    654.00 (MYOCARDIAL INFARCTION)
                                         ----    -----------


                    TOTAL LOS:           10    DXLS: 654.00 (MYOCARDIAL INFARCTION)
```

Patient Billing Reports Menu
Third Party Output Menu
Veterans w/Insurance and Inpatient Admissions

INTRODUCTION

The Veterans w/Insurance and Inpatient Admissions option is used to produce a list of all patients who have reimbursable insurance and who had admissions to the medical center during a selected date range. For dates of care prior to 10/1/90, service-connected veterans with insurance who were treated for a non service-connected condition (from the PTF record) will be included on the list. This list may be used to help insure that a bill exists for all inpatient billable episodes of care for the selected date range.

You may include unbilled patients, previously billed patients, or both on the report. If you choose to print ALL (both unbilled and previously billed), the report is sorted by these two categories. The unbilled patients portion displays the patient ID#, patient name, SSN, eligibility status, date of care (event date), and the patient's insurance companies. The previously billed list displays the same data plus every bill within the selected date range for each patient showing the bill number, bill rate type, statement from and to dates, and the debtor.

The lists are printed in alphabetical order by patient name or numerically by terminal digit (8th and 9th digit of the SSN, then 6th and 7th, etc.). For multidivisional sites, you may print a list for each division.

Depending on the size of your database and the date range selected, this report could be quite lengthy. It is recommended the report be queued to print during non-peak user hours.

The chart beginning on the following page shows the prompts and steps involved in using this option.

Patient Billing Reports Menu
Third Party Output Menu
Veterans w/Insurance and Inpatient Admissions

PROCESS

The following chart shows the prompts and steps involved in using the Veterans w/Insurance and Inpatient Admissions option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Start with DATE:	.date with which to begin the report	2
		.<RET> or up-arrow <^>	7
2	Go to DATE:	.date to end report	3
	This prompt will appear only for multidivisional facilities. If a specific division is selected, the prompt will repeat until a <RET> is entered.		
3	Select division: ALL//	.<RET> to accept the default and print a report for all divisions	4
		.specific division	3
		.<??> for division list	3
4	Select one of the following: 1 UNBILLED 2 BILLED 3 ALL PRINT LISTING: UNBILLED//	.<RET> or 1 for unbilled patients	5
		.2 for previously billed patients	5
		.3 for all	5
5	Sort by (P)atient Name or (T)erminal Digit: P//	.<RET> or Patient to sort alphabetically by patient name	6
		.Terminal Digit to sort numerically by terminal digit	6

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
6	You will be prompted for a device at this step.		
7	Return to the menu.		

Patient Billing Reports Menu
Third Party Output Menu
Veterans w/Insurance and Inpatient Admissions

EXAMPLE
The following is an example of what might appear on the screen while using this option. User responses are shown in boldface type. A copy of the output is provided below. When generated, the two categories (UNBILLED PATIENTS and PREVIOUSLY BILLED PATIENTS) will appear on separate pages.

```
Start with DATE: 2-1-92  (FEB 01, 1992)
Go to DATE: 2/29/92  (FEB 29, 1992)
Select division: ALL// ALBANY
Select another division: <RET>

     Select one of the following:

          1         UNBILLED
          2         BILLED
          3         ALL

PRINT LISTING: UNBILLED// 3  ALL
Sort by (P)atient Name or (T)erminal Digit: P// <RET>   PATIENT NAME

*** Margin width of this output is 132 ***
*** This output should be queued ***

DEVICE: HOME// A137   HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// YES  (YES)

Requested Start Time: NOW//  T@6:00   (MAR 01,1992@06:00)

Request Queued!
```

```
Veterans with Reimbursable Insurance and INPATIENT Admissions for period covering FEB 1,1992 through FEB 29, 1992
UNBILLED PATIENTS for Division ALBANY                          Printed: MAR 01,1992@06:00    Page: 1
PT ID  PATIENT          SSN           ELIGIBILITY       DATE OF CARE          INSURANCE COMPANIES
================================================================================================
1344   ALLSOP,MICKEY    128-10-1344   NON-SERVICE CONN  FEB 05,1992@15:51:15  AETNA

8900   BAKER,HARRY      097-14-0900   NON-SERVICE CONN  FEB 13,1992@13:40     NATIONWIDE
```

```
Veterans with Reimbursable Insurance and INPATIENT Admissions for period covering FEB 1,1992 through FEB 29, 1992
PREVIOUSLY BILLED PATIENTS for Division ALBANY                 Printed: MAR 01,1992@06:00    Page: 1
PT ID  PATIENT          SSN           ELIGIBILITY        DATE OF CARE          INSURANCE COMPANIES
================================================================================================

6152   COOPER,CAROL     112-52-6152    NON-SERVICE CONN   FEB 1,1992@11:10      PRUDENTIAL
          000272    REIM INS-INPT     From: 02/01/92    To: 02/10/92        Debtor: PRUDENTIAL

6251   HAYES,ALVIN      115-12-6251    NON-SERVICE CONN   FEB 24,1992@08:09     UNITED WORKERS
          000312    REIM INS-INPT     From: 02/24/92    To: 02/28/92        Debtor: UNITED WORKERS
          000346    REIM INS-INPT     From: 02/28/92    To: 02/29/92        Debtor: UNITED WORKERS

6192   TRAYHAN,PAUL     233-30-6192    NON-SERVICE CONN   FEB 10,1992@13:34     INTERNATIONAL
          000287    REIM INS-INPT     From: 02/10/92    To: 02/14/92        Debtor: INTERNATIONAL
```

Patient Billing Reports Menu
Third Party Output Menu
Veterans w/Insurance and Opt. Visits

INTRODUCTION

The Veterans w/Insurance and Opt. Visits option is used to produce a list of all patients who have reimbursable insurance and who had outpatient visits to the medical center during a selected date range. For dates of care prior to 10/1/90, service-connected veterans with insurance will be included on the list.

Non-count clinics and unbillable appointment types are excluded from the list. This list may be used to help insure that a bill exists for all outpatient billable episodes of care for that time frame.

This report includes patients who have either add/edit stop codes, 10-10 registrations, or scheduled appointments during the selected date range. The stop code, registration type, or clinic is included on the output for each entry. This information may be used to aid in determining how a charge should be billed.

You may include unbilled patients, previously billed patients, or both on the report. If you choose to print ALL (both unbilled and previously billed), the report is sorted by these two categories. The unbilled patients portion displays the patient ID#, patient name, SSN, eligibility status, date of care (event date), and the patient's insurance companies. The previously billed list displays the same data plus every bill within the selected date range for each patient showing the bill number, bill rate type, statement from and to dates, and the debtor.

The lists are printed in alphabetical order by patient name or numerically by terminal digit (8th and 9th digit of the SSN, then 6th and 7th, etc.). For multidivisional sites, you may print a list for each division.

Depending on the size of your database and the date range selected, this report could be quite lengthy. It is recommended the report be queued to print during non-peak user hours.

The chart beginning on the following page shows the prompts and steps involved in using this option.

Patient Billing Reports Menu
Third Party Output Menu
Veterans w/Insurance and Opt. Visits

PROCESS

The following chart shows the prompts and steps involved in using the Veterans w/Insurance and Opt. Visits option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Start with DATE:	.date with which to begin the report	2
		.<RET> or up-arrow <^>	7
2	Go to DATE:	.date to end report	3
	This prompt will appear only for multidivisional facilities. If a specific division is selected, the prompt will repeat until a <RET> is entered.		
3	Select division: ALL//	.<RET> to accept the default and print a report for all divisions	4
		.specific division	3
		.<??> for list of divisions	3
4	Select one of the following: 1 UNBILLED 2 BILLED 3 ALL PRINT LISTING: UNBILLED//	.<RET> or 1 for unbilled patients	5
		.2 for previously billed patients	5
		.3 for all	5
5	Sort by (P)atient Name or (T)erminal Digit: P//	.<RET> or patient to sort alphabetically by patient name	6
		.Terminal Digit to sort numerically by terminal digit	6

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
6	You will be prompted for a device at this step.		
7	Return to the menu.		

Patient Billing Reports Menu
Third Party Output Menu
Veterans w/Insurance and Opt. Visits

EXAMPLE

The following is an example of what might appear on the screen while using the Veterans w/Insurance and Opt. Visits option. User responses are shown in boldface type. A copy of the output is provided on the following page. When generated, the two categories (UNBILLED PATIENTS and PREVIOUSLY BILLED PATIENTS) will appear on separate pages. If you are printing more than one division at multidivisional sites, each division will print on a separate page.

```
Start with DATE: 2-1-92  (FEB 01, 1992)
Go to DATE: 2/29/92  (FEB 29, 1992)
Select division: ALL// ALBANY
Select another division: <RET>

     Select one of the following:

          1         UNBILLED
          2         BILLED
          3         ALL

PRINT LISTING: UNBILLED// 3  ALL
Sort by (P)atient Name or (T)erminal Digit: P// <RET>   PATIENT NAME

*** Margin width of this output is 132 ***
*** This output should be queued ***

DEVICE: HOME// A137   HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// YES  (YES)

Requested Start Time: NOW//  T@6:00   (MAR 01,1992@06:00)

Request Queued!
```

Patient Billing Reports Menu
Third Party Output Menu
Veterans w/Insurance and Opt. Visits

EXAMPLE, cont.

```
Veterans with Reimbursable Insurance and OUTPATIENT Appointments for period covering FEB 1,1992 through FEB 29, 1992
UNBILLED PATIENTS for Division ALBANY                          Printed: MAR 01,1992@06:00    Page: 1
PT ID  PATIENT          SSN          ELIGIBILITY        DATE OF CARE          INSURANCE COMPANIES
================================================================================================
9877   DERRICK,WILLIAM  987-09-9877  NON-SERVICE CONN   FEB 12,1992@09:45     PRUDENTIAL
           Add/Edit Stop Code with 900,

1233   FEDDERMAN,SCOTT  097-12-1233  NON-SERVICE CONN   FEB 23,1992@13:40     AETNA
           Clinic: DERMATOLOGY
1233   FEDDERMAN,SCOTT  097-12-1233  NON-SERVICE CONN   FEB 29,1992@09:44     AETNA
           Clinic: DERMATOLOGY


4577   NORTH,ANDREW     121-52-4577  NON-SERVICE CONN   FEB 18,1992@23:45     BLUE SHIELD
           Registration: HOSPITAL ADMISSION
```

```
Veterans with Reimbursable Insurance and OUTPATIENT Appointments for period covering FEB 1,1992 through FEB 29, 1992
PREVIOUSLY BILLED PATIENTS for Division ALBANY                 Printed: MAR 01,1992@06:00    Page: 1
PT ID  PATIENT          SSN          ELIGIBILITY       DATE OF CARE          INSURANCE COMPANIES
================================================================================================

6112   HANKSON,JAMES    112-22-6112   NON-SERVICE CONN  FEB 11,1992@14:34     BLUE CROSS
           Add/Edit Stop Code with 102, 301, 706
           00024A    REIM INS-OUTP    From: 02/11/92    To: 02/11/92          Debtor: BLUE CROSS

3321   MALLORY,JOHN     083-83-3321   NON-SERVICE CONN  FEB 12,1992@07:09     AETNA INSURANCE
           Clinic: MEDICAL
           00089A    REIM INS-OUTP    From: 02/12/92    To: 02/12/92          Debtor: AETNA INSURANCE
3321   MALLORY,JOHN     083-83-3321   NON-SERVICE CONN  FEB 26,1992@09:45     AETNA INSURANCE
           Clinic: MEDICAL
           00096A    REIM INS-OUTP    From: 02/26/92    To: 02/29/92          Debtor: AETNA INSURANCE
```

Patient Billing Reports Menu
Third Party Output Menu
Patient Review Document

INTRODUCTION

The Patient Review Document option is used to print the Third Party Review Form by patient name and admission date specifications. This form is used in connection with veteran patients admitted to the hospital who have private medical insurance. The form provides patient's name, patient ID#, admission date, diagnoses, and ward location. Insurance information provided includes insurance company name, address and phone number, policy number, and group number. The insurance data is not displayed if the insurance has expired.

The form is then divided into four sections. Section one concerns pre-admission certification. It shows whether or not pre-admission certification is required. If required, it provides information concerning the decision made by the insurance company regarding the admission. Information includes number of days certified, whether medical information is insufficient, and whether outpatient care is more appropriate. Section two concerns the need for a second surgical opinion, if required, and results of the second opinion. Section three provides information concerning the length of stay review; if further stay was approved or if disapproved, the reasons for denial. Section four shows bill status - denied in full, denied in part, or paid in full. If denied, the reasons for denial are given. The bill number is also shown.

The chart beginning on the following page shows the prompts and steps involved in producing a report using this option.

Patient Billing Reports Menu
Third Party Output Menu
Patient Review Document

PROCESS
The following chart shows the prompts and steps involved in using the Patient Review Document option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select PATIENT NAME:	.a patient's name	2
		.<RET> or up-arrow <^>	6
2	If the patient has had past admissions or is currently an active patient		3
	If the patient has had no past admissions but is scheduled to be admitted:		
	"No admissions on file, will check scheduled admissions"		5
	If the patient has neither past nor scheduled admissions:		
	"No admissions on file, will check scheduled admissions"		
	"No scheduled admissions on file"		6
3	Select Movement for {NAME entered at Step 1}:	.admission date for report you wish to see	5
		.<??> for list of admission dates	3
		.<RET> or up-arrow <^>	4
4	"Since an admission was not chosen, scheduled admissions for this patient will be checked"		
	If there are scheduled admissions on file, the system will proceed to Step 5 and the Third Party Review Form printed will be for the next scheduled admission date. If there are no scheduled admissions on file, the following will be displayed.		
	"No scheduled admissions on file."		6

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
5	"This report requires 132 column output" You will be prompted for a device at this Step.		
6	Return to the menu.		

Patient Billing Reports Menu
Third Party Output Menu
Patient Review Document

EXAMPLE
Following is an example of what might appear on the screen while using the Patient Review Document option. User responses are shown in boldface type. An example of the Third Party Review Form is provided on the following page.

```
Select PATIENT NAME:  FISH,FRANCIS   04-04-33   123456789   NSC VETERAN
Select Movement for FISH,FRANCIS:  6-26-90@08:00   FISH,FRANCIS  (134237890)
               ADMISSION: DIRECT

This report requires 132 column output

DEVICE: HOME//  WAITING AREA PRINTER    RIGHT MARGIN: 132//  <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO//  Y   (YES)

Requested Start Time: NOW//  <RET>   (DEC 12,1990@07:12)

Request Queued!
```

Patient Billing Reports Menu
Third Party Output Menu
Patient Review Document

EXAMPLE, cont.

```
NAME:  FISH, FRANCIS                                                    DATE PRINTED:  DEC 12, 1990
                                                                                PT ID:  123456789

INSURANCE CARRIER:  ABC Insurance Company
          ADDRESS:  234 Third St., Loma Linda, California  15436
            PHONE:  888-4789                  POLICY #:  6740879BB          GROUP #:  10
   PRE-CERT PHONE:                          BILLING PHONE:


INSURANCE CARRIER:
          ADDRESS:
            PHONE:                               POLICY #:                  GROUP #:
   PRE-CERT PHONE:                          BILLING PHONE:


INSURANCE CARRIER:
          ADDRESS:
            PHONE:                               POLICY #:                  GROUP #:
   PRE-CERT PHONE:                          BILLING PHONE:


ADMITTING DX:  Pneumonia                                          WARD:  8A
SCHEDULED ADMISSION DATE:                                       ADMISSION DATE:  JUN 26, 1986
-------------------------------------------------------------------------------------------------
PRE-ADMISSION CERTIFICATION:
___NUMBER DAYS CERTIFIED                              _____________________AUTHORIZATION NUMBER
___NOT REQUIRED
___FAILURE TO MEET ESTABLISHED ADMISSION CRITERIA
___MEDICAL INFORMATION IS INSUFFICIENT
___OPT CARE IS MORE APPROPRIATE
___OTHER LEVELS OF SERVICE ARE MORE APPROPRIATE (NURSING HOME VS HOSPITAL)
___POLICY DOES NOT COVER MEDICAL CARE REQUIRED
___COVERAGE EXHAUSTED
___OTHER                                                          PREPARED BY _____________________
-------------------------------------------------------------------------------------------------
SECOND SURGICAL OPINION NEEDED:    _______YES    _______NO
SECOND SURGICAL OPINION OBTAINED:  _______YES            ________OUTSIDE MD RECOMMENDED AGAINST SURGERY
                                   _______NOT APPLICABLE  ________OTHER
                                   _______NOT RECEIVED              PREPARED BY _____________________
-------------------------------------------------------------------------------------------------
LOS REVIEW DATE:   ___________                    DATE APPROVED:   _________________
NUMBER OF DAYS EXTENDED:   ___________                             _________________AUTHORIZATION NUMBER
___PRE-OP DAYS DENIED                          ___APPROPRIATE ALTERNATIVE TREATMENT OPTIONS EXIST
___MORE MEDICAL INFORMATION NEEDED             ___ALTERNATIVE TREATMENT NOT COVERED BY POLICY
___FAILURE TO MEET CONTINUED STAY CRITERIA     ___AVAILABILITY OF ALTERNATIVE TREATMENT
___APPROPRIATE ALTERNATIVE TREATMENT OPTIONS EXIST  ___COVERAGE EXHAUSTED
___OTHER                                                          PREPARED BY _____________________
-------------------------------------------------------------------------------------------------
BILLS DENIED IN FULL:                          BILL DENIED IN PART:
_____EXCLUSIONARY CLAUSE STILL IN EFFECT       _____DEDUCTIBLE/COPAYMENT APPLIES
_____DEDUCTIBLE/COPAYMENT APPLIES              _____PORTION OF CARE NOT COVERED BY POLICY
_____TYPE OF CARE NOT COVERED BY POLICY        _____EXCEEDS USUAL AND CUSTOMARY CHARGES
_____PATIENT DOES NOT HAVE CURRENT COVERAGE    _____PAYMENT LIMITED TO PREAUTHORIZED DAYS
_____INSURER WILL NOT PAY PER DIEM RATES       _____OTHER
_____TREATMENT/ADMISSION NOT AUTHORIZED BY INSURANCE CARRIER
_____OTHER                                     _____BILL PAID IN FULL
                                                     PREPARED BY _____________________
-------------------------------------------------------------------------------------------------
REMARKS:


BILL # _____________
```

Third Party Output Menu
Inpatients w/Unknown or Expired Insurance

INTRODUCTION

This option allows you to print a list of veteran inpatients with no insurance, expiring insurance (expired or will expire within 30 days), or unknown insurance. You may include any or all of these categories. The output may then be used to obtain insurance information from veterans while they are current inpatients.

If your site is multidivisional, one, many, or all divisions may be included. A subtotal is provided for each division.

The report may be printed for the current date or a specified date range. When you select a date range, all patients who were admitted during that date range are included. If you choose to display for the current date, all patients who are currently inpatients are included. The report may be further sorted by ward.

Producing this output may be very time consuming. It is recommended you queue this option to be run during off hours. The required margin width is 132 columns.

Information provided on the output may include division, ward, patient name, address, phone number, age, service-connected percentage, marital status, employment status, employer name, address, phone number, and patient ID.

The chart beginning on the following page shows the prompts and steps involved in using this option.

Third Party Output Menu
Inpatients w/Unknown or Expired Insurance

PROCESS

The following chart shows the prompts and steps involved in using the Inpatients w/Unknown or Expired Insurance option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select division: ALL//	.<RET> to accept default	2
		.division name (prompt will repeat until a <RET> is entered)	2
		.up-arrow <^>	9
	Select one of the following: D (D)ATE RANGE C (C)URRENT DATE		
2	Display report for:	.D for date range	3
		.C for current date	4
3	Start with DATE:		
	Go to DATE:	.date range you wish to include	4
4	Include veterans whose insurance is unknown? YES//	.<RET> to accept default	5
		.NO	5
5	Include veterans whose insurance is expiring? YES//	.<RET> to accept default and include veterans whose insurance has expired or will expire within 30 days	6
		.NO	6
6	Include veterans who have no insurance? YES//	.<RET> to accept default	7
		.NO	7

Third Party Output Menu
Inpatients w/Unknown or Expired Insurance

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
7	Do you want the report sorted by WARD, as well as by division and patient?	.YES	8
		.NO	8
8	"*** Margin width of this output is 132 *** *** This output should be queued ***"		
	You will be prompted for a device at this step.		9
9	Return to the menu.		

Third Party Output Menu
Inpatients w/Unknown or Expired Insurance

EXAMPLE
The following example shows what might appear on your screen while using this option. User responses appear in boldface type. A sample output begins on the following page.

```
Select division: ALL// NORTHSIDE
Select another division: <RET>

     Select one of the following:

          D         (D)ATE RANGE
          C         (C)URRENT DATE

Display report for: D  (D)ATE RANGE
Start with DATE:  T-10  (MAY 22, 1993)
Go to DATE:  T  (JUN 01, 1993)
Include veterans whose insurance is unknown? YES// <RET>
Include veterans whose insurance is expiring? YES// <RET>
Include veterans who have no insurance? YES// <RET>
Do you want the report sorted by WARD, as well as by division and
patient? YES

*** Margin width of this output is 132 ***
*** This output should be queued ***
DEVICE: HOME// A137    HALLWAY HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW// T@1700  (JUN 01, 1993@17:00:00)
REQUEST QUEUED TASK=5771
```

Third Party Output Menu
Inpatients w/Unknown or Expired Insurance

EXAMPLE, cont.
When printing an actual output, each of the following three categories will print on a separate page.

JUN 1,1993 PAGE 1

VETERANS WITH NO INSURANCE THAT WERE ADMITTED BETWEEN MAY 22,1993 AND JUN 1,1993

PATIENT/WARD	PT ID	ADMISSION DATE	AGE	%SC	MARITAL STATUS	EMPLOYMENT STATUS
Division:	NORTHSIDE					
Ward:	11B					
CLAY,ROBERT	331-42-3342	MAY 22,1993@16:37	55	40	WIDOW/WIDOWER	EMPLOYED FULL TIME
11B	Address:	555 KILBOURN TROY,NY 12180			Tele:	518-272-9292
	Employer:	ACME CONSTRUCTION MAPLE AVE ALBANY,NY 12208			Tele:	518-462-0926
TRUHARDT,ANDREW	675-64-3543	MAY 30,1993@07:00	62	0	MARRIED	EMPLOYED FULL TIME
11B	Address:	300 1ST ST. ALBANY,NY 12208			Tele:	518-472-0909
	Employer:	ALBANY PLUMBING 23 RAILROAD AVE. ALBANY,NY 12208			Tele:	518-462-3311
Ward:	11C					
WELLS,DONALD	323-27-8645	JUN 1,1993@11:32	42	0	MARRIED	EMPLOYED FULL TIME
11C	Address:	121 SHERMAN AVE COHOES,NY 12184			Tele:	518-237-0097
	Employer:	VAMC ALBANY 113 HOLLAND AVE. ALBANY,NY 12208			Tele:	518-462-3311

Subtotal: 3
Total: 3

JUN 1,1993 PAGE 2

VETERANS WHOSE INSURANCE IS EXPIRED OR WILL EXPIRE WITHIN 30 DAYS THAT WERE ADMITTED BETWEEN MAY 22,1993 AND JUN 1,1993

PATIENT/WARD	PT ID	ADMISSION DATE	AGE	%SC	MARITAL STATUS	EMPLOYMENT STATUS
Division:	NORTHSIDE					
Ward:	11B					
GRAY,MATTHEW	331-42-3342	MAY 25,1993@16:37	35	0	WIDOW/WIDOWER	NOT EMPLOYED
11B	Address:	49 MAIN AVE TROY,NY 12180			Tele:	518-271-8374
	Insurance:	PRUDENTIAL			Expiration:	JUN 15,1993

Subtotal: 1
Total: 1

Third Party Output Menu
Inpatients w/Unknown or Expired Insurance

EXAMPLE, cont.

VETERANS WHOSE INSURANCE IS UNKNOWN THAT WERE ADMITTED BETWEEN MAY 22,1993 AND JUN 1,1993

PATIENT/WARD	PT ID	ADMISSION DATE	AGE	%SC	MARITAL STATUS	EMPLOYMENT STATUS
Division:	NORTHSIDE					
Ward:	11C					
ADAMS,JOHN	097-42-3342	MAY 22,1993@16:37	82	10	WIDOW/WIDOWER	RETIRED
11C	Address:	55 LINCOLN AVE TROY,NY 12180			Tele:	518-270-9090
KAGAN,PETER	122-64-3543	MAY 25,1993@07:00	60	0	MARRIED	EMPLOYED FULL TIME
11C	Address:	256 HOLLAND AVE. ALBANY,NY 12208			Tele:	518-462-0786
	Employer:	GAVIN'S SECURITY 519 4TH ST TROY,NY 12208			Tele:	518-273-7485

Subtotal: 2

Total: 2

Patient Billing Reports Menu
Third Party Output Menu
Outpatients w/Unknown or Expired Insurance

INTRODUCTION

This option allows you to print a list of veteran outpatients with no insurance, expiring insurance (expired or will expire within 30 days), or unknown insurance for a specified date range. You may include any or all of these categories.

One, many, or all divisions (if your site is multidivisional) and clinics may be included. A subtotal is provided for each division/clinic.

This option may be used to identify those patients who should be interviewed for insurance information while visiting a specified clinic. This report may be printed for a specified date or range of dates and sent to the appropriate clinic for follow-up.

This output may be very time consuming and should be queued. The margin width is 132 columns.

The chart beginning on the following page shows the prompts and steps involved in producing this output.

Patient Billing Reports Menu
Third Party Output Menu
Outpatients w/Unknown or Expired Insurance

PROCESS
The following chart shows the prompts and steps involved in using the Outpatients w/Unknown or Expired Insurance option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Select division: ALL//	.<RET> to accept default	2
		.division name (prompt will repeat until a <RET> is entered - limit 20)	1
		.up-arrow <^>	8
2	Select clinic: ALL//	.<RET> to accept default	3
		.clinic name (prompt will repeat until a <RET> is entered - limit 20)	2
		.up-arrow <^>	8
3	Include veterans whose insurance is unknown? YES//	.<RET> to accept default	4
		.NO	4
4	Include veterans whose insurance is expiring? YES//	.<RET> to accept default and include veterans whose insurance has expired or will expire within 30 days	5
		.NO	5
5	Include veterans who have no insurance? YES//	.<RET> to accept default	6
		.NO	6
6	Start with DATE:		
	Go to DATE:	.date range you wish to include	7

Patient Billing Reports Menu
Third Party Output Menu
Outpatients w/Unknown or Expired Insurance

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
7	You will be prompted for a device at this step. The margin width of this output is 132.		8
8	Return to the menu.		

Patient Billing Reports Menu
Third Party Output Menu
Outpatients w/Unknown or Expired Insurance

EXAMPLE
The following example shows what might appear on your screen while using this option followed by a sample output. User responses are shown in boldface type. When actually printing this report, each category (expiring/unknown/no insurance) and each division (if your site is multidivisional) will print on a separate page.

```
Select division: ALL// <RET>
Select clinic: ALL// <RET>
Include veterans whose insurance is unknown? YES// <RET>
Include veterans whose insurance is expiring? YES// <RET>
Include veterans who have no insurance? YES// <RET>
Start with DATE:  T-10  (MAY 22, 1992)
Go to DATE:  T  (JUN 01, 1992)

*** Margin width of this output is 132 ***
*** This output should be queued ***
DEVICE: HOME// A137    HALLWAY HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW//T@1700  (JUN 01, 1992@17:00:00)
REQUEST QUEUED TASK=5771
```

Patient Billing Reports Menu
Third Party Output Menu
Outpatients w/Unknown or Expired Insurance

EXAMPLE, cont.

```
OUTPATIENT VISITS FOR VETERANS WITH NO INSURANCE                                          JUN 1,1992  PAGE 1
FOR APPOINTMENTS FROM MAY 22,1992 TO JUN 1,1992

   PATIENT NAME           PT ID              APPT DATE/TIME     AGE     %SC   MARITAL STATUS   EMPLOYMENT STATUS
-------------------------------------------------------------------------------------------------------------------

      Division:           ALBANY


      Clinic:             DERMATOLOGY

   CLAY,ROBERT            331-42-3342        MAY 22,1992@16:37   55      40   WIDOW/WIDOWER    EMPLOYED FULL TIME
                          Address:           555 KILBOURN                     Tele:            518-272-9292
                                             TROY,NY 12180
                          Employer:          ACME CONSTRUCTION                Tele:            518-462-0926
                                             MAPLE AVE
                                             ALBANY,NY 12208

   _____________________
   Clinic Subtotal  : 1

      Clinic:             ORTHOPEDIC

   WELLS,DONALD           323-27-8645        JUN 1,1992@11:32    42       0   MARRIED          EMPLOYED FULL TIME
                          Address:           121 SHERMAN AVE                  Tele:            518-237-0097
                                             COHOES,NY 12184
                          Employer:          VAMC ALBANY                      Tele:            518-462-3311
                                             113 HOLLAND AVE.
                                             ALBANY,NY 12208

   _____________________
   Clinic Subtotal  : 1

   _____________________
   Division Subtotal: 2

   _____________________
   Total            : 2
```

Patient Billing Reports Menu
Third Party Output Menu
Outpatients w/Unknown or Expired Insurance

EXAMPLE, cont.

```
OUTPATIENT VISITS FOR VETERANS WHOSE INSURANCE IS EXPIRED OR WILL EXPIRE WITHIN 30 DAYS        JUN 1,1992  PAGE 1
FOR APPOINTMENTS FROM MAY 22,1992 TO JUN 1,1992

   PATIENT NAME             PT ID              APPT DATE/TIME      AGE    %SC   MARITAL STATUS   EMPLOYMENT STATUS
-------------------------------------------------------------------------------------------------------------------

      Division:             ALBANY

      Clinic:               OPHTHALMOLOGY

   GRAY,MATTHEW             331-42-3342        MAY 25,1992@16:37   35       0   WIDOW/WIDOWER    NOT EMPLOYED
                            Address:           49 MAIN AVE                      Tele:            518-271-8374
                                               TROY,NY 12180
                            Insurance:         PRUDENTIAL                       Expiration:      JUN 15,1992

   _____________________
   Clinic Subtotal  : 1

   _____________________
   Division Subtotal: 1

   _____________________
   Total            : 1
```

```
OUTPATIENT VISITS FOR VETERANS WHOSE INSURANCE IS UNKNOWN                                        JUN 1,1992  PAGE 1
FOR APPOINTMENTS FROM MAY 22,1992 TO JUN 1,1992

   PATIENT NAME             PT ID              APPT DATE/TIME      AGE    %SC   MARITAL STATUS   EMPLOYMENT STATUS
-------------------------------------------------------------------------------------------------------------------

      Division:             ALBANY

      Clinic:               MEDICAL

   ADAMS,JOHN               097-42-3342        MAY 22,1992@16:37   82      10   WIDOW/WIDOWER    RETIRED
                            Address:           55 LINCOLN AVE                   Tele:            518-270-9090
                                               TROY,NY 12180

   _____________________
   Clinic Subtotal  : 1

      Clinic:               SURGICAL

   KAGAN,PETER              122-64-3543        MAY 25,1990@07:00   60       0   MARRIED          EMPLOYED FULL TIME
                            Address:           256 HOLLAND AVE.                 Tele:            518-462-0786
                                               ALBANY,NY 12208
                            Employer:          GAVIN'S SECURITY                 Tele:            518-273-7485
                                               519 4TH ST
                                               TROY,NY 12208

   _____________________
   Clinic Subtotal  : 1

   _____________________
   Division Subtotal: 2

   _____________________
   Total            : 2
```

Patient Billing Reports Menu
Single Patient Category C Billing Profile

INTRODUCTION

The Single Patient Category C Billing Profile option provides a list of all Means Test/Category C charges within a specified date range for a selected patient.

You will be prompted for patient name, date range, and device. The default at the "Start with DATE" prompt is October 1, 1990. This is the earliest date for which charges may be displayed.

This output displays the date the Category C billing clock began, bill date, bill type (including the treating specialty for inpatient copay charges), the bill number, bill to date (for inpatient charges), amount of each charge, and the total charges for the selected date range.

Due to the brevity of this option, a process chart is not provided.

Patient Billing Reports Menu
Single Patient Category C Billing Profile

EXAMPLE
Below is an example of what may appear on the screen while using the Single Patient Category C Billing Profile option followed by a sample output. User responses are shown in boldface type.

```
Select PATIENT NAME: WARREN,SCOTT      01-01-55     112321110     NSC VETERAN
Start with DATE: OCT 01, 1990// 2/26/91  (FEB 26, 1991)
Go to DATE: FEB 26, 1992// <RET> (FEB 26, 1992)
DEVICE: HOME// A137   HP LASER    RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

```
           Category C Billing Profile for WARREN,SCOTT  112-32-1110
From 02/26/91 through 02/26/92        FEB 10, 1994@13:56               Page: 1
BILL DATE   BILL TYPE                        BILL #   BILL TO   TOT CHARGE
-------------------------------------------------------------------------------

04/28/91    Begin Category C Billing Clock
04/28/91      OPT COPAYMENT                  L10038                  $26.00
09/07/91      INPT PER DIEM                  L10085   09/08/91       $20.00
09/07/91      INPT CO-PAY (NEU)              L10084   09/08/91      $628.00
02/10/92      OPT COPAYMENT                  L10038                  $30.00
02/24/92      OPT COPAYMENT                  L10038                  $30.00
                                                                  -----------
                                                                     $774.00
```

Patient Billing Reports Menu
Check off Sheet Print

INTRODUCTION

This option allows you to print Ambulatory Surgery Check-Off Sheets that have been set up through the Build CPT Check-off Sheet option. The check-off sheets printed through this option are generic and may therefore be used for any patient. A space is provided in the upper left corner for the patient card imprint.

A check-off sheet is not necessarily associated with a particular clinic and may be used for several clinics.

This report requires 132 column margin width.

Due to the brevity of this option, no process chart is provided.

Patient Billing Reports Menu
Check off Sheet Print

EXAMPLE
Below is an example of what may appear on your screen while using the Check off Sheet Print option followed by a sample output on the next page. User responses are shown in boldface type.

```
Print Clinic Check-Off Sheet


Select AMBULATORY CHECK-OFF SHEET NAME: DERMATOLOGY
         ...OK? YES// <RET>  (YES)
Select AMBULATORY CHECK-OFF SHEET NAME: <RET>

This report requires a 132 column printer.
DEVICE: HOME// A137         HP LASER    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)
```

Patient Billing Reports Menu
Check off Sheet Print

EXAMPLE, cont.

Ambulatory Surgery Check-Off Sheet
CPT Codes for DERMATOLOGY

Date:

REMOVAL OF SKIN LESION, TRUNK, ARMS, OR LEGS

11400	benign 0.5cm or less		( )
11600	malig. 0.5cm or less		( )
11401	benign .06 to 1.0cm		( )
11601	malig. 0.6 to 1.0cm		( )
11402	benign 1.1 to 2.0cm		( )
11602	malig. 1.1 to 2.0cm		( )
11606	benign over 4.0cm		( )
11643	malig. 2.1 to 4.0cm		( )
11644	malig 3.1 to 4.0cm		( )

REMOVAL OF SKIN LESION, SCALP, NECK, HANDS

11420	benign 0.5cm or less		( )
11620	malig. .05cm or less		( )
11421	benign .06 to 1.0cm		( )
11621	malig. 0.6 to 1.0 cm		( )
11422	benign 1.1 to 20.cm		( )
11622	malig. 1.1 to 2.0cm		( )
11426	benign over 4.0cm	306.24	( )

REMOVAL OF SKIN LESION, FACE, EARS, EYELIDS

11440	benign 0.5cm or less		( )
11640	malig. 0.5cm or less		( )
11441	benign .06 to 1.0cm		( )
11641	malig 0.6 to 1.0cm		( )
11442	benign 1.1 to 2cm		( )
11642	malig 1.1 to 2cm		( )
11446	benign over 4.0cm	306.24	( )
11646	malig over 4.0cm		( )

MISCELLANEOUS

40654	repair lip	306.24	( )
11000	biopsy of lesion	666.40	( )
11101	biopsy of additional lesion		( )
11200	removal of skin (15)		( )
11201	removal of skin (over 15)		( )
11730	removal of plate	228.80	( )
12011	repair superficial wound		( )
17000	destruction of face lesion		( )
17001	destruction of face lesions 2&3		( )
17002	destruction of face lesions, over 3		( )

REMOVAL OF TUMOR

21555	neck/chest		( )
23075	shoulder		( )
24075	upper arm/elbow		( )
25075	forearm/wrist		( )
26115	hand/finger		( )
27618	lower leg		( )
28043	foot		( )

DRAIN

10003	sebaceous cyst		( )
10101	infected nail (s)		( )
10141	hematoma	306.24	( )

CLEANSING

11000	surgical of skin	666.40	( )
11001	each add 10%		( )
11042	debridement skin subq	306.24	( )

TRIM

11050	skin lesion (1)		( )
11051	skin lesion (2-4)		( )
11052	skin lesion (over 4)		( )

REMOVAL

11731	second nail plate	306.24	( )
11750	nail bed	352.00	( )
11752	nail bed/fingertip		( )

CLOSURE

12020	split wound (simple)	666.40	( )
12021	split wound (packing)	685.52	( )

Third Party Billing Menu
Print Bill Addendum Sheet

INTRODUCTION

This option is used to print the addendum sheets that may accompany HCFA-1500 prescription refill or prosthetic bills. The addendum contains information that could not fit on the bill form.

Prescription refill data provided on the addendum sheet may include prescription number, refill date, drug, quantity, # of days supply, and the National Drug Code (NDC) #. Prosthetic data will include the date delivered to the patient and the item.

In order for the bill addendums to automatically print for every HCFA-1500 bill with prescription refills or prosthetic items, the billing default printer for the BILL ADDENDUM form type must be set through the Select Default Device for Forms option found on the System Manager's Integrated Billing Menu.

You will be prompted for the bill number and a device. Due to the brevity of this option, a process chart has not been provided.

Third Party Billing Menu
Print Bill Addendum Sheet

EXAMPLE
The following example shows what might appear on your screen while using this option followed by a sample output. User responses appear in boldface type.

```
Select BILL NUMBER: N10088     NUNN,VICTOR     01-03-94     OUTPATIENT
REIMBURSABLE INS.     PRINTED


Report requires 132 columns.
OUTPUT DEVICE: HOME// A200       RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

Requested Start Time: NOW// <RET>  (JAN 25, 1994@14:46:16)
```

```
BILL ADDENDUM FOR NUNN,VICTOR - N10088                          JAN 28, 1994  11:00   PAGE 1
-------------------------------------------------------------------------------------------------

PRESCRIPTION REFILLS:

481     Jan 03, 1994     DIGOXIN 0.25MG         QTY: 60     DAYS SUPPLY: 30     NDC #: 19-929-922
432     Jan 10, 1994     NAPROXEX 250MG S.T.    QTY: 10     DAYS SUPPLY: 10     NDC #: 22-834-871


PROSTHETIC ITEMS:

JAN 02, 1994     WALKER-FOLDING-WHEELED
JAN 02, 1994     CANE-ALL OTHER
```

Third Party Billing Menu
Authorize Bill Generation

INTRODUCTION

The Authorize Bill Generation option is used to authorize the printing of third party bills and the release of the information to Fiscal Service.

When a billing record is selected, the system performs a check to determine if another user is currently processing the same record. If not, the system will lock the record. If the lock is unsuccessful, it means another user already has that record locked and the following message will be displayed.

"No further processing of this record permitted at this time. Record locked by another user. Try again later."

A final review/edit of the information in the billing record may be performed through this option. The data is arranged so that it may be viewed and edited through various screens. The data is grouped into sections for editing. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by brackets ([ ]) may be edited while those enclosed by arrows (< >) may not. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient), and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the data groups found on that screen and also provides the name and number of each available screen in the option. For more detailed documentation on editing a bill, please see the Enter/Edit Billing Information option documentation.

SCREEN 1
DEMOGRAPHIC
INFORMATION

The Demographic Screen contains patient information such as date of birth, marital status, address, phone number, and whether or not the patient was service connected for any condition at the time the care on the bill was rendered. Much of this screen is automatically filled in from data in the PATIENT file.

INTRODUCTION, cont.

SCREEN 2 EMPLOYMENT INFORMATION	The Employment Screen lists the patient's employer and his/her employment status. Employment information concerning the patient's spouse may also be listed.
SCREEN 3 PAYER INFORMATION	Screen 3 contains information regarding who is responsible for payment of the bill; patient, insurer, or other. "Other" status may include another VA, a private hospital, etc.
SCREEN 4 EVENT INPATIENT INFORMATION	The Event - Inpatient Information Screen contains such data elements as admission and discharge dates, principal diagnosis, prosthetics, procedures, occurrence codes, value codes, and condition codes. Screen 4 appears for inpatient bills only.
SCREEN 5 EVENT OUTPATIENT INFORMATION	The Event - Outpatient Information Screen displays data concerning diagnosis, coding method, outpatient procedure codes, occurrence, value and condition codes, prosthetics, and prescription refills. Screen 5 appears for outpatient bills only.
SCREEN 6 & 7 BILLING GENERAL INFORMATION	The Billing Screen will appear differently for inpatient (Screen 6) and outpatient (Screen 7) episodes. Both screens include bill from and to dates, charges, bill type, time frame, release of sensitive information, covered/non-covered charges, revenue codes and charges, and assignment of benefits.
SCREEN 8 BILLING SPECIFIC INFORMATION	For UB-92 forms, this screen contains the bill remark, treatment authorization code, admitting diagnosis, attending and other physicians, and those locators on the billing form which are unlabeled (locator 49 is uneditable). The UB-82 form excludes specific fields for the admitting diagnosis and physicians; however, they may be entered into the unlabeled form locators. For HCFA-1500 forms, this screen contains the unable to work from and to dates, Block 31 entry/edit, and treatment authorization code.

INTRODUCTION cont.

For a more detailed explanation of all screens, please see the Enter/Edit Billing Information option documentation.

The CAN INITIATOR AUTHORIZE? site parameter and the IB AUTHORIZE security key affect the prompts which appear at the end of this option.

CAN INITIATOR AUTHORIZE?
If set to YES, user who initiated the bill can authorize generation of billing form (if required security key held). If this parameter is set to NO, the initiator of the bill will not be allowed to authorize its generation.

IB AUTHORIZE
Allows the holder to authorize generation of bills. You must hold this key to access this option.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which may be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

The chart beginning on the following page shows the prompts and steps involved in using the Authorize Bill Generation option.

Third Party Billing Menu
Authorize Bill Generation

PROCESS

The following chart shows the prompts and steps involved in using the Authorize Bill Generation option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	Enter BILL NUMBER or PATIENT NAME:	.patient name	2
		.bill number	3
		.<RET> or up-arrow <^>	11
	If the selected patient's eligibility has not been verified and the ASK HINQ IN MCCR parameter is set to YES, you will be given the opportunity to enter a HINQ request in the HINQ Suspense file. Means Test information is also displayed.		
2	All applicable bills are listed for selection in reverse date order. The display provides the event date, bill number, rate type, bill status, and form type if different from the site parameter default form type. The bill to be authorized must be selected by the list number.		3
	If any inconsistencies are found in the bill, they are now listed. If there are no inconsistencies, you will proceed to Step 4. If you answer NO at this prompt, you will not be able to continue.		
3	Do you wish to edit inconsistencies now? NO//	.NO	1
		.YES	5
4	"No Errors found Entered: {DATE} by {NAME}"		
	WANT TO EDIT SCREENS? NO//	.<RET> or NO	6
		.YES	5

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
5	The screens listed below will now be displayed individually. The data is presented for viewing or editing. A <?> may be entered at most items for an explanation of that data field. After editing, the screen is redisplayed with the new values. I=inpatient bill screen O=outpatient bill screen B=both Screen 1 Demographic Information B Screen 2 Employment Information B Screen 3 Payer Information B Screen 4 Event-Inpatient Information I Screen 5 Event-Outpatient Information 0 Screen 6 Billing-General Information I Screen 7 Billing-General Information 0 Screen 8 Billing-Specific Information B The following prompt will appear at the bottom of each screen. <RET> to CONTINUE, 1-{#} to EDIT, '^N' for screen N, or '^' to QUIT: • <RET> at Screens 1 thru 7 will take you to the next appropriate screen. <RET> at Screen 8 will take you to Step 6. • Enter the field group number(s) you wish to edit using commas and dashes as delimiters. • Up-arrow <^> and the number of the screen you wish to see will take you to that screen. • Up-arrow <^> will return you to Step 3 (if any inconsistencies exist) or Step 6.		
6	WANT TO AUTHORIZE BILL AT THIS TIME? NO//	.<RET> or NO .YES	1 7
7	AUTHORIZE BILL GENERATION?:	.NO .YES	8 9

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	This prompt will repeat until a <RET> is entered.		
8	Select REASON(S) DISAPPROVED-INITIAL:	.reason for disapproval	8
		.<??>for list of reasons	8
		.<RET>	1
9	"Passing completed Bill to Accounts Receivable. Bill is no longer editable. Completed Bill Successfully sent to Accounts Receivable. Entered: {DATE} by {NAME} Authorized: {DATE} by {NAME}" WANT TO PRINT BILL AT THIS TIME? NO//	.<RET> or NO	1
		.YES	10
10	You will be prompted for a device at this Step. The device prompt will appear with a default if one has been entered through the Select Default Device for Forms option for the type of form you are printing.		1
11	Return to the menu.		

Third Party Billing Menu
Authorize Bill Generation

EXAMPLE
The following is an example of what might appear on the screen while using the Authorize Bill Generation option. User responses are shown in boldface type.

```
Enter BILL NUMBER or PATIENT NAME:  900008A  CARLSON,IAN  02-11-92
  Outpatient     MEANS TEST/CAT. C     ENTERED/NOT REVIEWED

Patient is Category C based on Means Test
Has agreed to pay deductible
Means Test Last Applied 'OCT 19,1991'.
No Errors found

Entered        : FEB 11, 1992 by ANDERSON,ROBERT

WANT TO EDIT SCREENS? NO//  <RET>   (NO)

WANT TO AUTHORIZE BILL AT THIS TIME? NO//  Y   (YES)
AUTHORIZE BILL GENERATION?:  Y   (YES)
Passing completed Bill to Accounts Receivable.  Bill is no longer
editable.  Completed Bill Successfully sent to Accounts Receivable.

Entered        : FEB 11, 1992 by ANDERSON,ROBERT
Authorized     : FEB 11, 1992 by MCFADDEN,CHUCK

WANT TO PRINT BILL AT THIS TIME? NO//  <RET>
```

Third Party Billing Menu
Enter/Edit Billing Information

INTRODUCTION

The Enter/Edit Billing Information option is used to enter the information required to generate a third party bill and to edit existing billing information. A new bill may be entered or an existing bill can be edited, as long as the existing bill has not been authorized or cancelled. Once a bill has been filed (billing record number established), it cannot be deleted. The bill may be cancelled through the Cancel Bill option.

If the selected patient's eligibility has not been verified and the ASK HINQ IN MCCR parameter is set to YES, the user will have the opportunity to enter a HINQ (Hospital Inquiry) request into the HINQ Suspense File. This request will be transmitted to the Veterans Benefits Administration to obtain the patient's eligibility information. If Means Test data such as category, Means Test last applied, and date Means Test completed is available, it will be displayed after the patient name or bill number has been entered.

When entering a new bill, the system will prompt for EVENT DATE. When billing for multiple outpatient visits, the date of the initial visit is used. For an inpatient bill, the date of the admission is used. If an interim bill is being issued, the EVENT DATE should be the date of admission for that episode of care.

The Medical Care Cost Recovery data is arranged so that it may be viewed and edited through various screens. The data is grouped into sections for editing. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by brackets ([ ]) may be edited while those enclosed by arrows (< >) may not. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient) and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the data groups found on that screen and also provides the name and number of each available screen in the option.

INTRODUCTION, cont.

SCREEN 1 DEMOGRAPHIC INFORMATION

The Demographic Screen contains patient information such as date of birth, marital status, address, phone number (although the phone number is not displayed, it is included in Group 5) and whether or not the patient was service connected for any condition at the time the care on the bill was rendered. Much of this screen is automatically filled in from data in the PATIENT file. Users who do not hold the DG ELIGIBILITY security key will only be able to edit the alias, address, and patient short address prompts. The Patient Short Address prompt is for a shortened version of the patient's address if over 47 characters (to fit on the billing form).

SCREEN 2 EMPLOYMENT INFORMATION

The Employment Screen lists the patient's employer, employer address, and his/her employment status. The spouse's employer may also be listed. Spouse's employment data will only be editable if the patient is married or separated.

SCREEN 3 PAYER INFORMATION

Screen 3 contains information regarding rate type and who is responsible for payment of the bill; patient, insurer, or other. OTHER status may include another VA, a private hospital, etc. You can make a new entry to the INSTITUTION file from this screen.

The bill mailing address appears on this screen. Please see the Data Supplement at the end of this option documentation for important information on how this is determined.

When insurance companies are entered into the INSURANCE COMPANY file, the system prompts for whether or not this company will reimburse VA for the cost of the patient's care. Entry of an insurance company that has been designated as "will not reimburse" is not allowed at this screen. For bills where the payer is the insurance company and the patient has one insurance company that will reimburse the government, that company will be stored as the primary insurance company.

INTRODUCTION cont.

Inactivating the insurance company has no effect on the insurance carriers associated with the bill.

Selection of insurance companies is limited to the primary, secondary, and tertiary insurance companies that are billable for the event date. A provider number may be entered for each of the three possible insurance carriers. This field will be loaded from the Hospital Provider Number if one has been entered for the insurance carrier.

Insurance company addresses can only be edited through the Insurance Company Entry/Edit option.

If the MULTIPLE FORM TYPES site parameter is set to YES, a form type prompt will appear. The UB-82 and UB-92 are considered a single form so for a site to have multiple forms they would have to use one of the UB forms and the HCFA-1500.

Changing the form type to HCFA-1500 will cause the CODING METHOD field to default to CPT-4 if it has not already been defined. Changing the primary insurance carrier or responsible institution will cause the revenue codes to be rebuilt and charges to be recalculated.

SCREEN 4 EVENT INPATIENT INFORMATION

Screen 4 appears for inpatient bills only. This screen includes data concerning admission and discharge dates, principal diagnosis and procedures, prosthetics, and for accidents, the time the accident occurred. If the MCCR site parameter CAN CLERK ENTER NON-PTF CODES? is set to YES, diagnosis and procedure codes not found in the PTF record may be input into the billing record. Occurrence, condition, and value codes also appear on this screen.

A print order can be specified for each procedure/diagnosis entered. If no print order is specified, the procedures/ diagnoses will print in the order entered. The six procedures and nine diagnoses with the lowest print order will be printed in the boxes on the form and the remainder will print as additional procedures/diagnoses.

INTRODUCTION, cont.

SCREEN 5 EVENT OUTPATIENT INFORMATION

Screen 5 appears for outpatient bills only. This screen displays data concerning the diagnosis, coding method, and outpatient procedure codes. The coding method must be specified before outpatient procedure codes may be entered/edited. Diagnosis coding is possible on this screen. Information concerning prosthetics and prescription refills is located here. Occurrence, condition, and value codes also appear on this screen.

If the MCCR site parameter USE OP CPT SCREEN is set to YES, the Current Procedural Terminology Code Screen will appear when editing procedure codes. The screen will list CPT codes for the dates associated with the bill.

An associated diagnosis (diagnosis responsible for the procedure being performed) must be entered for each procedure for HCFA-1500s. You may enter from 1 to 4 associated diagnoses. The associated diagnosis must match one of the first four diagnoses entered.

Adding a BASC procedure or an OP VISIT DATE will cause the revenue codes to be rebuilt and charges recalculated for both UB-82/92 and HCFA-1500 form types. Only one visit date is allowed on a UB-82/92 that also has BASC procedures. This restriction does not apply to HCFA-1500s.

A print order may be specified for each procedure/diagnosis entered. If no print order is specified, the procedures/diagnoses will print in the order entered. The six procedures and nine diagnoses with the lowest print order will be printed in the boxes on the form and the remainder will print as additional procedures/diagnoses.

If the TRANSFER PROCEDURES TO SCHED? parameter is set to YES, any ambulatory surgery entered on the bill can be transferred to the SCHEDULING VISITS file and stored under a 900 stop code. An associated clinic must be entered for all procedures that are to be transferred to the SCHEDULING VISITS file.

INTRODUCTION, cont.

SCREEN 6 & 7 BILLING GENERAL INFORMATION

The Billing Screen appears differently for inpatient (Screen 6) and outpatient (Screen 7) episodes. Both screens include bill from and to dates, charges, bill type, time frame, covered and non-covered days, and assignment of benefits. If the billing period crosses fiscal or calendar years, two separate bills must be prepared (one for each fiscal/calendar year). Adding an OP VISIT DATE or entering the STATEMENT FROM and STATEMENT TO dates will cause the revenue codes to be rebuilt and charges to be recalculated for both UB-82/92 and HCFA-1500 forms.

Screen 6 also contains the discharge bedsection and length of stay (in days). The automatic length of stay calculation excludes the date of discharge. For interim first and interim continuous bills, each day is addded to the length of stay so interim bills do not overlap. Screen 7 allows for input of outpatient visit dates, up to 30 visits per bill. Only one visit date is allowed on UB-82/92s that also have BASC procedures. This restriction does not apply to HCFA-1500s.

Revenue codes and rates are automatically calculated. You may add additional revenue codes. Each revenue code will be associated with a bedsection.

When editing a sensitive record, (one which contains information pertaining to drugs, alcohol, sickle cell anemia, or other sensitive information), the user will be prompted for R.O.I. form. This field denotes whether or not release of information forms have been signed.

When entering an offset amount (amount to be subtracted from the total charges on the bill; i.e., copayment, deductible), entry of an offset description may also be entered.

When entering a third party bill (anything not billed to the patient), the ASSIGNMENT OF BENEFITS field will automatically be set to YES and cannot be edited.

INTRODUCTION, cont.

SCREEN 8 BILLING SPECIFIC INFORMATION

For UB-92 forms, this screen contains the bill remark, treatment authorization code, admitting diagnosis, attending and other physicians, and those locators on the billing form which are unlabeled (locator 49 is uneditable). The UB-82 form excludes specific fields for the admitting diagnosis and the physicians; however, they may be entered into the unlabeled form locators. For HCFA-1500 forms, this screen contains the unable to work from and to dates, Block 31 entry/edit, and treatment authorization code.

Several site parameters and two security keys affect the prompts which appear at the end of this option. Please see the Data Supplement at the end of this option documentation for an explanation of how these site parameters and security keys affect the option.

A mail group may be specified (through the site parameters) so that every time a bill is disapproved during the authorization phase of the billing process, all members of this group are notified via electronic mail. If this group is not specified, only the billing supervisor, the initiator of the billing record, and the user who disapproved the bill will be recipients of the message. An example of this message can be found in the Data Supplement.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which may be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

Only holders of the IB EDIT security key may access this option.

The chart beginning on the following page shows the prompts and steps involved in using the Enter/Edit Billing Information option.

Third Party Billing Menu
Enter/Edit Billing Information

PROCESS

The following chart shows the prompts and steps involved in using the Enter/Edit Billing Information option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	Patient selected must be in the PATIENT file.		
1	Enter BILL NUMBER or PATIENT NAME:	.patient name (with previously established open billing records)	2
		.patient name (without established records)	3
		.bill number	18
		.<RET> or up-arrow <^>	30
	If the selected patient's eligibility has not been verified and the ASK HINQ IN MCCR parameter is set to YES, you will be given the opportunity to enter a HINQ request in the HINQ Suspense File. Means Test information is also displayed.		
2	All bills which have been entered for that patient but NOT cancelled or printed are displayed for selection in reverse date order in groups of five. The display provides event date, bill number rate type, bill status, and form type if different from the site parameter default form type. The bill to be edited must be selected by the list number. If a <RET> or up-arrow <^> is entered at the "CHOOSE" prompt, you will proceed to Step 3.		18
3	DO YOU WANT TO ESTABLISH A NEW BILLING RECORD FOR {'pt.name'}? NO//	.YES	4
		.<RET> or NO	1
	Entering an up-arrow <^> at Steps 4 thru 9 will abort the bill creation process. A default value of "1" signifies HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.		
4	BILLING LOCATION OF CARE: 1//	.<RET> to accept default	5
		.type of facility	5
		.<?> for list of choices	4

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
5	BILLING BILL CLASSIFICATION:	.bill classification	6
		.<?> for list of choices	5
6	BILLING TIMEFRAME OF BILL:	.bill frequency	7
		.<?> for list of choices	6
	Enter YES if record contains information pertaining to drugs, alcohol, sickle cell anemia, or other sensitive information.		
7	BILLING IS THIS A SENSITIVE RECORD?: NO//	.<RET> or 0 or NO	8
		.1 or YES	8
8	BILLING RATE TYPE:	.category of bill	9
		.<??> for list of rate types	8
	Which of the following prompts appears will depend on what was entered at Step 5.		
9	BILLING OUTPATIENT EVENT DATE:	.date of outpatient treatment	12
	OR		
	The system will automatically list VA admissions and those non-VA admissions that have an associated PTF record for selection. You may enter a date for which there is no admission or associated PTF record.		
	CHOOSE 1-{#} or Enter DATE:	.displayed date	12
		.undisplayed date	10

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
10	ARE YOU BILLING FOR AN UNDISPLAYED EPISODE OF CARE? NO//	.NO or <RET>	9
		.YES	11
11	NON-VA DISCHARGE DATE:	.date of discharge	12
		.<RET> to leave blank	12

If a bill has been previously created for the event date selected at Step 9, the following display format will appear. All the data should be checked to make sure you are not entering a duplicate bill.

Bill # Classif Payer Event DT From Dat To Date Status Timeframe

12	BILLING STATEMENT COVERS FROM: {date}//	.beginning date of services covered by this bill	13
		.<RET> to accept default	13
13	BILLING STATEMENT COVERS TO: {date}//	.ending date of services covered by this bill	14
		.<RET> to accept default	14

The prompts at Steps 14 and 15 will only appear if you are entering/editing an outpatient bill, the selected patient has other bills, and there are no other visits for the selected event date.

14	ARE YOU BILLING FOR A CONTINUING EPISODE OF CARE? NO//	.<RET> or NO	16
		.YES	15

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	Past bills will be listed in the format display shown at Step 12 for selection of the appropriate bill number.		
15	CHOOSE 1-{#} or ENTER BILL NUMBER:	.bill number	16
		.<RET> or up-arrow <^>	14
	All of the information which has been entered at the previous prompts is now displayed with the following message.		
16	"Please verify the above information for the bill you just entered. Once this information is accepted it will no longer be editable and you will be required to CANCEL THE BILL if changes to this information are necessary."		
	IS THE ABOVE INFORMATION CORRECT AS SHOWN? YES//	.<RET> or YES	17
		.NO	4
17	Numerous messages are displayed showing what actions are being taken by the software.		18
18	The screens listed below will now be displayed individually. The data is presented for viewing/editing. A <?> may be entered at most items for an explanation of that data field. After editing, the screen is redisplayed with the new values.		

I=inpatient bill screen O=outpatient bill screen B=both

Screen 1	Demographic Information	B
Screen 2	Employment Information	B
Screen 3	Payer Information	B
Screen 4	Event-Inpatient Information	I
Screen 5	Event-Outpatient Information	0
Screen 6	Billing-General Information	I
Screen 7	Billing-General Information	0
Screen 8	Billing-Specific Information	B

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	The following prompt will appear at the bottom of each screen.		
18 cont.	<RET> to CONTINUE, 1-{#} to EDIT, '^N' for screen N, or '^' to QUIT: • <RET> at Screens 1 thru 7 will take you to the next appropriate screen. <RET> at Screen 8 will take you to Step 19. • Enter the field group number(s) you wish to edit using commas and dashes as delimiters. • Up-arrow <^> and the number of the screen you wish to see will take you to that screen. • Up-arrow <^> will return you to Step 1.		
	All inconsistencies found in the bill are now listed. If there are no inconsistencies, you will proceed to Step 20. If you answer NO at this prompt, you will not be able to continue. If you answer YES at this prompt, upon completion you will proceed to Step 21.		
19	Do you wish to edit inconsistencies now? NO//	.NO .YES	1 18
	The "Authorized.." line will only appear if applicable to the selected bill.		
20	"No Errors found Entered: {DATE} by {NAME} Authorized: {DATE} by {NAME}" WANT TO EDIT SCREENS? NO//	.<RET> or NO .YES	21 18
	The "Entered..." line will only appear if you reached this step after editing inconsistencies.		
21	"Entered: {DATE} by {NAME}" WANT TO AUTHORIZE BILL AT THIS TIME? NO//	.<RET> or NO .YES	1 22

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
22	AUTHORIZE BILL GENERATION?:	.NO or up-arrow <^>	23
		.YES	24
	This prompt will repeat until a <RET> is entered.		
23	Select REASON(S) DISAPPROVED-INITIAL:	.reason for disapproval	23
		.<??> for a list of reasons	23
		.<RET>	1
24	"Passing completed Bill to Accounts Receivable. Bill is no longer editable. Completed Bill Successfully sent to Accounts Receivable. Entered: {DATE} by {NAME} Authorized: {DATE} by {NAME}" WANT TO PRINT BILL AT THIS TIME? NO//	.<RET> or NO	1
		.YES	25
25	You will be prompted for a device at this Step. The device prompt will appear with a default if one has been entered through the Select Default Device for Forms option for the type of form you are printing.		1
26	Return to the menu.		

Third Party Billing Menu
Enter/Edit Billing Information

EXAMPLE

The following are examples of what may appear on the screen while using the Enter/Edit Billing Information option. User responses are shown in boldface type. Copies of printed billing forms are included in the Print Bill option documentation.

EXAMPLE 1 - INPATIENT BILL

```
Enter BILL NUMBER or PATIENT NAME: SMITH,HERMAN     09-14-60   242548783   NSC
VETERAN

Patient Requires a Means Test
Means Test Required from 'AUG 6,1992'.

No OPEN billing records on file for this patient.

DO YOU WANT TO ESTABLISH A NEW BILLING RECORD FOR 'SMITH,HERMAN'? NO// Y  (YES)
   BILLING LOCATION OF CARE: 1// 1  HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
   BILLING BILL CLASSIFICATION: 1  INPATIENT (MEDICARE PART A)
   BILLING TIMEFRAME OF BILL: 1  ADMIT THRU DISCHARGE CLAIM
   BILLING IS THIS A SENSITIVE RECORD?: NO// <RET>  (NO)
   BILLING RATE TYPE:  REIMBURSABLE INS.       Who's Responsible: INSURER

Insurance Co.     Subscriber ID     Group       Holder  Effective Expires
================================================================================
HEALTH INSURANCE  0234511233        MERCY HOSP  SELF    01/01/90  01/01/96

Select INPATIENT EVENT (ADMISSION) DATE:
    1   MAY 23,1992@13:00           2   AUG 23,1984

CHOOSE 1-2 or Enter DATE:  1
PTF record indicates 0 of 1 movements are for Service Connected Care.

Bill #  Classif  Payer  Event DT  From Dat  To Date   Status  Timeframe
------  -------  -----  --------  --------  --------  ------  ----------
L10450  Inpat.   Insur  05/23/92  05/23/92  05/31/92  Cancel  1 Ad - Ds

   BILLING STATEMENT COVERS FROM: MAY 23,1992// <RET>  (MAY 23, 1992)
   BILLING STATEMENT COVERS TO: MAY 31,1992// <RET>  (MAY 31, 1992)
```

EXAMPLE 1, cont.

```
SMITH,HERMAN (242-54-8783)                                    DOB: SEP 14,1960
================================================================================
Rate Type    :  REIMBURSABLE INS.
Event Date   :  MAY 23,1992@13:00
Sensitive    :  NO
Responsible  :  INSURANCE CARRIER  (Specify CARRIER on SCREEN 3)

Bill Type    :  111
  o 1st Digit:  1 - HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
  o 2nd Digit:  1 - INPATIENT (MEDICARE PART A)
  o 3rd Digit:  1 - ADMIT THRU DISCHARGE CLAIM

Bill From    :  MAY 23,1992
Bill To      :  MAY 31,1992

PTF Number   :  1734

Please verify the above information for the bill you just entered.  Once this
information is accepted it will no longer be editable and you will be required
to CANCEL THE BILL if changes to this information are necessary.

IS THE ABOVE INFORMATION CORRECT AS SHOWN? YES// <RET>  (YES)
Passing bill to Accounts Receivable Module...
Billing Record #L10451 being established for 'SMITH,HERMAN'...
Cross-referencing new billing entry...

Billing Record #L10451 established for 'SMITH,HERMAN'...
Updating PTF Record #1734...
Now updating ward CDR information...completed.
Updating Revenue Codes
          REV. CODE   UNITS    CHARGE       BEDSECTION
Adding      101         8      $  386.00    GENERAL MEDICAL CARE
Adding      240         8      $  169.00    GENERAL MEDICAL CARE
Adding      960         8      $  132.00    GENERAL MEDICAL CARE




SMITH,HERMAN   242-54-8783   BILL#: L10451 - Inpatient              SCREEN <1>
================================================================================
                              DEMOGRAPHIC INFORMATION
[1] DOB    : SEP 14,1960
[2] Alias  : NO ALIAS ON FILE
[3] Sex    : MALE                                Marital: NEVER MARRIED
[4] Veteran: YES                               Eligibility: NON-SERVICE CONNECTED

[5] Address: 414 UNION AVENUE                   Temporary: NO TEMPORARY ADDRESS
             PROVIDENCE, RI 02904

[6] Pt Short
    Address: 414 UNION AVENUE,PROVIDENCE,RI 02904

[7] SC Care: NO


<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>
```

EXAMPLE 1, cont.

```
SMITH,HERMAN   242-54-8783   BILL#: L10451 - Inpatient              SCREEN <2>
================================================================================
                              EMPLOYMENT INFORMATION
[1] Employer: MERCY HOSPITAL            <2> Spouse's: UNSPECIFIED
              150 S MAIN ST
              PROVIDENCE, RI 02903
       Phone: 401-456-0099
  Occupation: MEDICAL DATA CLERK
      Status: EMPLOYED FULL TIME


<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>




SMITH,HERMAN   242-54-8783   BILL#: L10451 - Inpatient              SCREEN <3>
================================================================================
                                 PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.          Form Type: UB-92
    Payer      : INSURER
    Insurance 1: HEALTH INSURANCE LTD.      Policy #: 0234511233
    Group #    : 21J-15                     Group Name: MERCY HOSP EMPL
    Whose      : VETERAN                    Sex of Insured: MALE
    Insured    : SMITH,HERMAN               Rel. to Insured: PATIENT


[2] Primary Provider #  : 999
    Secondary Provider #:                   Tertiary Provider #:


[3] Mailing Address :
    HEALTH INSURANCE LTD.
    23 3RD ST
    TROY, NY  12181


<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>
```

EXAMPLE 1, cont.

```
SMITH,HERMAN   242-54-8783   BILL#: L10451 - Inpatient              SCREEN <4>
================================================================================
                          EVENT - INPATIENT INFORMATION
                          PTF record status: OPEN
[1] Admission  : MAY 23,1992@13:00              Accident Hour: 99
    Source     : CLINIC REFERRAL                        Type: URGENT
[2] Discharge  : MAY 31,1992@16:25
    Status     : DISCHARGED TO HOME OR SELF CARE
[3] Prin. Diag.: STREPTOCOCCAL PNEUMONIA - 482.3
    Other Diag.: DIABETES UNCOMPL JUVEN/IDDM - 250.01
[4] Cod. Method: ICD-9-CM
[5] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[6] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[7] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[8] Value Code : UNSPECIFIED [NOT REQUIRED]


<RET> to CONTINUE, 1-8 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>
```

```
SMITH,HERMAN   242-54-8783   BILL#: L10451 - Inpatient              SCREEN <6>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type    : 111                          Timeframe: ADMIT THRU DISCHARGE
    Covered Days : UNSPECIFIED           Non-Covered Days: UNSPECIFIED
[2] Sensitive?   : NO                          Assignment: YES
[3] Bill From    : MAY 23, 1992                   Bill To: MAY 31, 1992
[4] Bedsection   : GENERAL MEDICAL CARE
    LOS          : 8
[5] Rev. Code    : 101-ALL INCL R&B       Charges:   $3,088.00  GENERAL MEDICAL
    Rev. Code    : 240-ALL INCL ANCIL     Charges:   $1,352.00  GENERAL MEDICAL
    Rev. Code    : 960-PRO FEE            Charges:   $1,056.00  GENERAL MEDICAL
    OFFSET       :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL   :   $5,496.00
    FY 1         : 92                     Charges:   $5,496.00


<RET> to CONTINUE, 1-5 to EDIT, '^N' for screen N, or '^' to QUIT: 1

TIMEFRAME OF BILL: ADMIT THRU DISCHARGE CLAIM// <RET>
COVERED DAYS: 8
NON-COVERED DAYS: 1
```

EXAMPLE 1, cont.

```
SMITH,HERMAN   242-54-8783   BILL#: L10451 - Inpatient              SCREEN <6>
================================================================================
                         BILLING - GENERAL INFORMATION
[1] Bill Type    : 111                          Timeframe: ADMIT THRU DISCHARGE
    Covered Days : 8                      Non-Covered Days: 1
[2] Sensitive?   : NO                           Assignment: YES
[3] Bill From    : MAY 23, 1992                   Bill To: MAY 31, 1992
[4] Bedsection   : GENERAL MEDICAL CARE
    LOS          : 8
[5] Rev. Code    : 101-ALL INCL R&B       Charges:   $3,088.00  GENERAL MEDICAL
    Rev. Code    : 240-ALL INCL ANCIL     Charges:   $1,352.00  GENERAL MEDICAL
    Rev. Code    : 960-PRO FEE            Charges:   $1,056.00  GENERAL MEDICAL
    OFFSET       :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL   :   $5,496.00
    FY 1         : 92                     Charges:   $5,496.00


<RET> to CONTINUE, 1-5 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>



SMITH,HERMAN   242-54-8783   BILL#: L10451 - Inpatient              SCREEN <8>
================================================================================
                         BILLING - SPECIFIC INFORMATION
[1] Bill Remark     : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code   : UNSPECIFIED [NOT REQUIRED]
    Admitting Dx    : UNSPECIFIED [NOT REQUIRED]
[2} Attending Phy.  : VAD001
    Other Physician : UNSPECIFIED [NOT REQUIRED]
[3] Form Locator 2  : UNSPECIFIED [NOT REQUIRED]
    Form Locator 11 : UNSPECIFIED [NOT REQUIRED]
[4] Form Locator 31 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 37 : UNSPECIFIED [NOT REQUIRED]
[5] Form Locator 56 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 57 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 78 : UNSPECIFIED [NOT REQUIRED]


<RET> to QUIT, 1-5 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>

No Errors found

Entered        : AUG  6, 1992 by DERDERIAN,JOHN

WANT TO EDIT SCREENS? NO//  <RET>   (NO)

WANT TO AUTHORIZE BILL AT THIS TIME? NO// Y  (YES)
AUTHORIZE BILL GENERATION?: Y  (YES)
Passing completed Bill to Accounts Receivable.  Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.

Entered        : AUG  6, 1992 by DERDERIAN,JOHN
Authorized     : AUG  6, 1992 by DERDERIAN,JOHN


WANT TO PRINT BILL AT THIS TIME? NO// Y  (YES)
Output Device: A200//  <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO//  <RET>   (NO)
```

Third Party Billing Menu
Enter/Edit Billing Information

EXAMPLE 2 - OUTPATIENT BILL

```
Enter BILL NUMBER or PATIENT NAME: SMITH,HERMAN       09-14-60    242548783   NSC VETERAN

Patient Requires a Means Test
Means Test Required from 'AUG 6,1992'.

No OPEN billing records on file for this patient.

DO YOU WANT TO ESTABLISH A NEW BILLING RECORD FOR 'SMITH,HERMAN'? NO// Y  (YES)
   BILLING LOCATION OF CARE: 1// 1  HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
   BILLING BILL CLASSIFICATION: 3  OUTPATIENT
   BILLING TIMEFRAME OF BILL: 1  ADMIT THRU DISCHARGE CLAIM
   BILLING IS THIS A SENSITIVE RECORD?: NO// <RET>  (NO)
   BILLING RATE TYPE:  REIMBURSABLE INS.       Who's Responsible: INSURER

Insurance Co.     Subscriber ID     Group       Holder  Effective Expires
=============================================================================
HEALTH INSURANCE  0234511233        MERCY HOSP  SELF    01/01/90  01/01/96

BILLING OUTPATIENT EVENT DATE:  060392  (JUN 03, 1992)

No Other Bills for this Episode Date on File!

   BILLING STATEMENT COVERS FROM: JUN 3,1992// <RET>  (JUN 03, 1992)
   BILLING STATEMENT COVERS TO: JUL 31,1992// 060392  (JUN 03, 1992)

ARE YOU BILLING FOR A CONTINUING EPISODE OF CARE? NO// <RET>  (NO)



SMITH,HERMAN (242-54-8783)                                  DOB: SEP 14,1960
=============================================================================
Rate Type    :  REIMBURSABLE INS.
Event Date   :  JUN 3,1992
Sensitive    :  NO
Responsible  :  INSURANCE CARRIER  (Specify CARRIER on SCREEN 3)

Bill Type    :  131
  o 1st Digit:  1 - HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
  o 2nd Digit:  3 - OUTPATIENT
  o 3rd Digit:  1 - ADMIT THRU DISCHARGE CLAIM

Bill From    :  JUN 3,1992
Bill To      :  JUN 3,1992

Please verify the above information for the bill you just entered.  Once this
information is accepted it will no longer be editable and you will be required
to CANCEL THE BILL if changes to this information are necessary.

IS THE ABOVE INFORMATION CORRECT AS SHOWN? YES// <RET>  (YES)
Passing bill to Accounts Receivable Module...
Billing Record #L10452 being established for 'SMITH,HERMAN'...
Cross-referencing new billing entry...

Billing Record #L10452 established for 'SMITH,HERMAN'...
```

Third Party Billing Menu
Enter/Edit Billing Information

EXAMPLE 2, cont.

```
SMITH,HERMAN   242-54-8783   BILL#: L10452 - Outpatient             SCREEN <1>
================================================================================
                            DEMOGRAPHIC INFORMATION
[1] DOB    : SEP 14,1960
[2] Alias  : NO ALIAS ON FILE
[3] Sex    : MALE                                Marital: NEVER MARRIED
[4] Veteran: YES                              Eligibility: NON-SERVICE CONNECTED

[5] Address: 414 UNION AVENUE                  Temporary: NO TEMPORARY ADDRESS
             PROVIDENCE, RI 02904

[6] Pt Short
    Address: 414 UNION AVENUE,PROVIDENCE,RI 02904

[7] SC Care: NO


<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>



SMITH,HERMAN   242-54-8783   BILL#: L10452 - Outpatient             SCREEN <2>
================================================================================
                            EMPLOYMENT INFORMATION
[1] Employer: MERCY HOSPITAL            <2> Spouse's: UNSPECIFIED
              150 S MAIN ST
              PROVIDENCE, RI 02903
       Phone: 401-456-0099
  Occupation: MEDICAL DATA CLERK
      Status: EMPLOYED FULL TIME


<RET> to CONTINUE, 1-2 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>



SMITH,HERMAN   242-54-8783   BILL#: L10452 - Outpatient             SCREEN <3>
================================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.          Form Type: UB-92
    Payer      : INSURER
    Insurance 1: HEALTH INSURANCE LTD.      Policy #: 0234511233
    Group #    : 21J-15                     Group Name: MERCY HOSP EMPL
    Whose      : VETERAN                    Sex of Insured: MALE
    Insured    : SMITH,HERMAN               Rel. to Insured: PATIENT


[2] Primary Provider #  : 7865
    Secondary Provider #:                   Tertiary Provider #:


[3] Mailing Address :
    HEALTH INSURANCE LTD.
    23 3RD ST
    TROY, NY  12181


<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>
```

EXAMPLE 2, cont.

```
SMITH,HERMAN   242-54-8783   BILL#: L10452 - Outpatient             SCREEN <5>
================================================================================
                          EVENT - OUTPATIENT INFORMATION
<1> Event Date : JUN 3, 1992
[2] Prin. Diag.: UNSPECIFIED [NOT REQUIRED]
[3] OP Visits  : UNSPECIFIED [NOT REQUIRED]
[4] Cod. Method: UNSPECIFIED [NOT REQUIRED]
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[9] Value Code : UNSPECIFIED [NOT REQUIRED]


<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT: 3


                  <<<OUTPATIENT VISITS>>>

================================================================================
NO.   VISIT DATE   ELIG/MT  CPT  CHARGE BILL# - TYPE        STOP CODE
===   ==========   =======  ===  ====== ============        =========
 1)  JUN  3, 1992  NSC          $148.00  L10452-REIM INS    GENERAL MEDICINE


Select visits to include in this bill (1-1): 1
YOU HAVE SELECTED VISIT(S) NUMBERED- 1
IS THIS CORRECT? YES// <RET>   (YES)
    Adding OP Visit Date of JUN  3, 1992
Select OP VISITS DATE(S): JUN 3,1992// <RET>
Updating Revenue Codes
          REV. CODE   UNITS    CHARGE       BEDSECTION
Adding      500         1      $  148.00    OUTPATIENT VISIT




SMITH,HERMAN   242-54-8783   BILL#: L10452 - Outpatient             SCREEN <5>
================================================================================
                          EVENT - OUTPATIENT INFORMATION
<1> Event Date : JUN 3, 1992
[2] Prin. Diag.: UNSPECIFIED [NOT REQUIRED]
[3] OP Visits  : JUN 3, 1992
[4] Cod. Method: UNSPECIFIED [NOT REQUIRED]
[5] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[6] Cond. Code : UNSPECIFIED [NOT REQUIRED]


<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>
```

EXAMPLE 2, cont.

```
SMITH,HERMAN   242-54-8783   BILL#: L10452 - Outpatient             SCREEN <7>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type    : 131                          Timeframe: ADMIT THRU DISCHARGE
    Covered Days : UNSPECIFIED           Non-Covered Days: UNSPECIFIED
[2] Sensitive?   : NO                          Assignment: YES
[3] Bill From    : JUN  3, 1992                   Bill To: JUN  3, 1992
[4] OP Visits    : JUN 3,1992,
[5] Rev. Code    : 500-OUTPATIENT SVS     Charges:     $148.00  OUTPATIENT VISIT
    OFFSET       :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL   :     $148.00
    FY 1         : 92                      Charges:     $148.00


<RET> to CONTINUE, 1-5 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>




SMITH,HERMAN   242-54-8783   BILL#: L10452 - Outpatient             SCREEN <8>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[1] Bill Remark     : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code   : UNSPECIFIED [NOT REQUIRED]
    Admitting Dx    : UNSPECIFIED [NOT REQUIRED]
[2} Attending Phy.  : VAD001
    Other Physician : UNSPECIFIED [NOT REQUIRED]
[3] Form Locator 2  : UNSPECIFIED [NOT REQUIRED]
    Form Locator 11 : UNSPECIFIED [NOT REQUIRED]
[4] Form Locator 31 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 37 : UNSPECIFIED [NOT REQUIRED]
[5] Form Locator 56 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 57 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 78 : UNSPECIFIED [NOT REQUIRED]


<RET> to QUIT, 1-5 to EDIT, '^N' for screen N, or '^' to QUIT: <RET>

No Errors found

Entered        : AUG  6, 1992 by DERDERIAN,JOHN

WANT TO EDIT SCREENS? NO//  <RET>   (NO)

WANT TO AUTHORIZE BILL AT THIS TIME? NO// Y  (YES)
AUTHORIZE BILL GENERATION?: Y  (YES)
Passing completed Bill to Accounts Receivable.  Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.

Entered        : AUG  6, 1992 by DERDERIAN,JOHN
Authorized     : AUG  6, 1992 by DERDERIAN,JOHN


WANT TO PRINT BILL AT THIS TIME? NO// Y  (YES)
Output Device: A200//  <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO//  Y   (YES)

Requested Start Time: NOW//  <RET>  (FEB 10,1990@09:45)
```

Third Party Billing Menu
Enter/Edit Billing Information

DATA SUPPLEMENT
This section is provided to give further clarification to the following elements which appear in the Enter/Edit Billing Information option.

Fields	Explanation of select fields (data items) found in this option.
Parameters and Security Keys	Explanation of select parameters and security keys which affect the functioning of this option.
Mail Messages	Example of electronic mail messages generated by this option.
Billing Mailing Address	Explanation of how the billing mailing address is determined.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
1	Patient Short Mailing Address	Abbreviated patient mailing address (if necessary). Address cannot exceed 47 characters for billing form.
1	SC at Time of Care	Was this patient service connected for any condition at the time the care in the bill was rendered. This field is used to correctly assign Accounts Receivable AMIS segments to this bill if it is a Reimbursable Insurance bill. The default for this field is the current value in the SC PATIENT field of the PATIENT file. If this field is left blank, the default value will be used to determine the AMIS segment.
3	Institution Name	When payer is "other", name of institution responsible for payment of bill (i.e., other VAMC, federal agency, private hospital).

DATA SUPPLEMENT, cont.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
3	Form Type	The type of form the bill is printed on. If the MULTIPLE FORM TYPES parameter is set to YES, this field will appear.
3	Primary/Secondary/ Tertiary Provider	The number assigned to the provider by the primary/secondary/tertiary payer.
4	Admission	Date of admission for inpatient bill (event date).
4	Source of Admission	Source of this patient admission; i.e., clinic referral.
4	Type of Admission	EMERGENCY - Used for emergency admissions. URGENT - Used for routine admissions. ELECTIVE - Cosmetic surgery, etc. (should not be used routinely).
4	Accident Hour	Time of accident or injury (to be used only with episodes of care resulting from an accident).
4	Discharge Status	Patient status at time of discharge; i.e., expired, left against medical advice.
4	Principal Diagnosis	Code of diagnosis responsible for patient's greatest length of stay for this inpatient hospital episode. Automatically filled in from PTF record, if available.
4	Principal Procedure	Principal surgery or procedure occurring during this inpatient hospital episode (if any). Automatically filled in from PTF record, if available.

DATA SUPPLEMENT, cont.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
4	Procedure Coding Method	Coding method used for procedure/surgery coding. The choices are CPT-4, HCPCS, or ICD-9-CM.
4, 5	Occurrence Code	Event relating to bill that may affect insurance processing (if applicable). Some codes relate to a single date while others relate to a date range.
4, 5	Condition Code	Condition relating to patient that may affect insurance processing (if applicable).
4, 5	Value Code	This code relates amounts or values to identified data elements necessary to process the claim as qualified.
4, 5	Order	This is the print order in which the procedures/diagnoses will appear on the form. The six lowest procedure and nine lowest diagnosis numbers will appear on the form in the boxes, the rest will print as additional procedures/diagnoses. If no print order is specified, the procedures/diagnoses will print in the order entered.
4, 5	Place of Service	Used in Block 24C of the HCFA-1500 form indicating where the procedure was provided.
4, 5	Type of Service	Used in Block 24D of the HCFA-1500 billing form indicating what kind of medical care was provided for this procedure.
4, 5	State	If the treatment is related to an automobile accident, this field is used to specify the location on the HCFA-1500 form.

DATA SUPPLEMENT, cont.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
5	Event Date	Outpatient bill (only one visit) - date of visit. Outpatient bill (multiple visits) - date of initial visit.
5	Associated Clinic	The clinic where the procedure was performed. This field must be completed for this procedure to be successfully transferred to the Add/Edit Stop code logic for inclusion in OPC workload.
5	Associated Diagnosis	This is the diagnosis for the procedure being performed. An associated diagnosis (up to 4) must be entered for each procedure when using the HCFA-1500 form. It must match one of the first four diagnoses entered.
5	Division	A division must be entered for all BASC procedures. This is required for the charge calculation.
5	Opt. Code	Code name/number for outpatient procedure/surgery performed. Bypass if no procedures/surgeries performed.
5, 7	OP Visits	Multiple field for outpatient bills. For facilities that bill more than one visit per bill, field where the facility can specify all the outpatient visit dates being billed (up to 30 per bill).
6	Discharge Bedsection	Patient's bedsection at time of discharge.
6	Length of Stay	Length of stay in days. Excludes the discharge date of all bills that are not interim first or interim continuous.

DATA SUPPLEMENT, cont.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
6, 7	Revenue Code	Code which identifies a specific accommodation, ancillary service, or billing calculation. May enter up to 10 active codes per bill. You may add codes for a patient from the list provided, but cannot add new codes to the list.
6, 7	Charges	Cost of 1 unit of service; i.e., 1 inpatient day, 1 outpatient visit.
6, 7	Units of Service	Number of units of service rendered to this patient for a specific revenue code.
6, 7	Offset Amount	Dollar amount that is to be subtracted from the total charges on this bill; i.e., copayments, deductibles.
6, 7	Bill Total	Units of service (x) charges for all Revenue codes.
6, 7	Statement Covers From	Statement covers services rendered from this date. Use event date if billing from admission through discharge or if billing for opt. services. Use beginning date of services covered by bill for interim billing. Interim inpatient bills should no longer overlap.
6, 7	Statement Covers To	Statement covers services rendered to this date. Use discharge date if billing from admission through discharge. Use date of last opt. visit for outpatient bills. Use ending date of services covered by bill for interim bills. Interim inpatient bills should no longer overlap.

DATA SUPPLEMENT, cont.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
6, 7	R.O.I. Form(s) Completed	Release of Information form completed or not completed.
6, 7	Assignment of Benefits	Will automatically be set to YES when entering a third party bill and will not be editable.
6, 7	Power of Attorney	Have Power of Attorney forms been signed? Will only appear if occurrence codes selected pertain to an accident.
6, 7	FY 1	Will be automatically set to fiscal year of event date and FY1 charges will equal bill total (offset not deducted).
6, 7	Procedure	Associates a particular revenue code charge with a specific CPT procedure on the HCFA-1500 form.
6, 7	Covered/Non-Covered Days	Number of days covered/not covered by the primary payer.
8	Bill Comment	Remarks associated with this bill which will print on the UB-82/92 form (2-35 characters).
8	Form Locator fields	Unlabeled fields on UB-82/92 form. Use may be determined at the state or national level after negotiations between payers and providers.
8	Treatment Authorization Code	Number or other indicator that designates that the treatment covered by this bill has been authorized by the payer.

DATA SUPPLEMENT, cont.

PARAMETERS

1. CAN INITIATOR AUTHORIZE	If set to YES, user who entered bill can authorize generation of billing form (if required security keys held). If this parameter is set to NO, the person who entered the bill will not be allowed to authorize its generation.
2. CAN CLERK ENTER NON-PTF CODES	If set to YES, user will be allowed to enter diagnosis and procedure codes not found in the PTF record into the billing record. User will also be able to select ICD-9-CM, CPT-4, or HCPCS as the procedure coding method and can enter CPT or ICD procedure codes into the billing record, if desired. If this parameter is set to NO, the user will be able to enter into the billing record only those diagnosis and procedure codes found in the PTF record associated with the episode of care being billed.
3. DEFAULT RX REFILL REV CODE	If entered, this revenue code will be used for all prescription refills on a bill when the revenue codes and charges are automatically calculated. This default will be overridden by the PRESCRIPTION REFILL REV. CODE for an insurance company, if one exists.

DATA SUPPLEMENT, cont.

PARAMETERS

4. TRANSFER PROCEDURES TO SCHED	CPT procedures may be stored as ambulatory procedures in the SCHEDULING VISITS file (using the Add/Edit Stop Code option), as well as in the billing record as procedures to print on a bill. There is now a two-way sharing of information between these two files. If this parameter is answered YES, as CPT procedures that are also ambulatory procedures are entered into a bill, the user will be prompted as to whether they should also be transferred to the SCHEDULING VISITS file. Conversely, through the USE OP CPT SCREEN? parameter you may allow importing of ambulatory procedures into a bill. Only CPT procedures that are Billable Ambulatory Surgical Codes, or either nationally or locally active ambulatory procedures may be transferred.
5. DEFAULT DIVISION	This field will be used as the default answer to the division question when entering billable ambulatory surgeries into a bill. Enter in this field the name of a division at your facility. It may be the main building, a satellite clinic, a domiciliary, or a nursing home.
6. MEDICARE PROVIDER NUMBER	The 1-8 character number provided by Medicare to the facility. This number will automatically print in Form Locator 7 on the UB-82.

DATA SUPPLEMENT, cont.

PARAMETERS

7. MULTIPLE FORM TYPES	Set this field to YES if the facility uses more than one type of health insurance form. The UB and the HCFA-1500 are the form types currently available. If set to NO or left blank, only UB forms will be allowed.
8. DEFAULT AMB SURG REV CODE	When billing Billable Ambulatory Surgical Codes (BASC), this will be the default revenue code stored in the bill. If this is not appropriate for any particular insurance company, the AMBULATORY SURG. REV. CODE field in the INSURANCE COMPANY file may be entered and it will be used for that particular insurance company entry.
9. ASK HINQ IN MCCR	If this parameter is answered YES, you may be asked if you would like to put a HINQ request in the HINQ SUSPENSE file when creating a new bill on a veteran with unverified eligibility.
10. USE OP CPT SCREEN	CPT codes for outpatient visits are currently stored as ambulatory procedures in the SCHEDULING VISITS file. If this parameter is set to YES, all CPT codes stored in the SCHEDULING VISITS file for the date range of the bill will be displayed when editing a bill. This display screen will prompt the user if they would like to easily import any or all of the CPT codes into the bill. This will include both ambulatory procedures and the billable ambulatory surgical codes.

DATA SUPPLEMENT, cont.

SECURITY KEYS

IB EDIT	Allows the holder to establish new billing records and edit existing records.
IB AUTHORIZE	Allows the holder to authorize generation of all bill form types.

MAIL MESSAGES

The following is an example of the mail message automatically sent when a bill is disapproved during the authorize phase of the billing process. Up to five reasons for disapproval may be listed in this message. If there are more than five reasons for disapproval, five reasons will be displayed followed by: "Other reasons too numerous to mention...".

```
Subj: MAS UB-82 BILL DISAPPROVAL BULLETIN  19 Apr 92 15:40  9 Lines
From: CHADWICK,MARJORIE  (Bronx VAMC) in 'IN' basket.
---------------------------------------------------------------------------

The following UB-82 bill has been disapproved:

Bill Number: 80009A

Patient Name: SPADE,ANTHONY                PT ID: 077-07-7777

Event Date: OCT 13,1991

Reason for disapproval: OTHER DIAGNOSES CODES UNSPECIFIED/INCORRECT


Select MESSAGE Action: IGNORE (in IN basket)//
```

DATA SUPPLEMENT, cont.

BILL MAILING ADDRESS

The following is an explanation of how the bill mailing address field on Screen 3 is determined.

WHO'S RESPONSIBLE	BILL MAILING ADDRESS IS
Patient	Patient's mailing address
Institution	
Institution has not been selected	Patient's mailing address
Institution has been selected	Institution's mailing address
Insurer	
Patient has no insurance company on file or more than one insurance company with none selected	No mailing address stored
Primary insurance company selected and bill is for inpatient stay and another company does not process the primary insurance company's inpatient claims	Primary insurance company's inpatient claims processing address
Primary insurance company selected and bill is for outpatient visit and another company does not process the primary insurance company's outpatient claims	Primary insurance company's outpatient claims processing address
Primary insurance company selected and bill is for inpatient stay and another company processes the primary insurance company's inpatient claims	Inpatient claims processing address of the company that processes the primary insurance company's inpatient claims
Primary insurance company selected and bill is for outpatient visit and another company processes the primary insurance company's outpatient claims	Outpatient claims processing address of the company that processes the primary insurance company's outpatient claims

DATA SUPPLEMENT, cont.

BILL MAILING ADDRESS

WHO'S RESPONSIBLE	BILL MAILING ADDRESS IS
Insurer, cont.	
Primary insurance company selected and the insured's employer should receive the insurance claims for pre-processing	Employer's claims processing address

If the mailing address is edited at any time, the edited address is stored. If a new rate type or insurance company is selected at any time, even if the mailing address has been edited, the mailing address will be determined as described above.

Third Party Billing Menu
Cancel Bill

INTRODUCTION

The Cancel Bill option allows the user to cancel a bill at any point in the billing process. Once the bill is cancelled, there is no way to view the data contained in that bill.

If you select a bill which has been previously cancelled, certain prompts will appear with defaults.

A mail group may be specified (through the site parameters) so that every time a bill is cancelled, all members of this group are notified through electronic mail. If this group is not specified, only the billing supervisor and the user who cancelled the bill will be recipients of the message. An example of this message may be found in the Example Section of this option.

Only holders of IB AUTHORIZE security key may access this option.

The chart on the following page shows the prompts and steps involved in using the Cancel Bill option.

Third Party Billing Menu
Cancel Bill

PROCESS

The following chart shows the prompts and steps involved in using the Cancel Bill option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	Only patients with established billing records may be entered.		
1	Enter BILL NUMBER or Patient NAME:	.bill number	3
		.patient name (with one billing record)	3
		.patient name (with multiple billing records)	2
		.<RET> or up-arrow <^>	7
2	All bills for the patient entered at Step 1 are listed for selection in groups of five. The bill to be cancelled must be selected by the list number.		3
3	ARE YOU SURE YOU WANT TO CANCEL THIS BILL? NO//	.<RET> or NO	1
		.YES	4
4	LAST CHANCE TO CHANGE YOUR MIND... CANCEL BILL?:	.<RET> or NO	1
		.YES	5
*5	REASON CANCELLED:	.reason (3-100 characters)	6
	This prompt appears only if the care listed on the bill is being tracked by Claims Tracking. "Since you have canceled this bill, you may enter a Reason Not Billable into Claims Tracking. This will take the care off of the UNBILLED lists" Claims Tracking entry: {billing information}		
6	REASON NOT BILLABLE:	.reason (?? for a list)	1
7	Return to the menu.		

*Required field

Third Party Billing Menu
Cancel Bill

EXAMPLE
The following is an example of what might appear on the screen while using the Cancel Bill option. User responses are shown in boldface type.

```
Enter BILL NUMBER or Patient NAME: GRANDELLI,ANGELO          01-01-11
008098123     NO     NSC VETERAN    N10276       GRANDELLI,ANGELO     03-12-95
Inpatient     REIMBURSABLE INS.

ARE YOU SURE YOU WANT TO CANCEL THIS BILL? NO// Y  (YES)

LAST CHANCE TO CHANGE YOUR MIND...
CANCEL BILL?: Y  (YES)
REASON CANCELLED: Patient is service connected.

...Bill has been cancelled...          .......

Since you have canceled this bill, you may enter a Reason Not Billable
into Claims Tracking.  This will take the care off of the UNBILLED lists.

Claims Tracking entry: 500512  INPATIENT ADMISSION  Mar 12, 1995@08:00
REASON NOT BILLABLE: 2  SC TREATMENT


Enter BILL NUMBER or Patient NAME:
```

EXAMPLE, cont.
The following is a sample of the type of mail message automatically sent when a bill is cancelled through this option.

```
Subj: MAS UB-92 BILL CANCELLATION BULLETIN  [#120774] 22 Mar 95 13:22  11 Lines
From: GRAY,MARY ELLEN (ALBANY ISC)  in 'IN' basket.   Page 1
---------------------------------------------------------------------------

The following UB-92 bill has been cancelled:

Bill Number: N10276

Patient Name: GRANDELLI,ANGELO         PT ID: 008-09-8123

Event Date: MAR 12,1995@08:00

Reason for cancellation: Patient is service connected.

Status when cancelled: CANCELLED  -  Not passed to AR


Select MESSAGE Action: IGNORE (in IN basket)//
```

Third Party Billing Menu
Copy and Cancel

INTRODUCTION

The Copy and Cancel option is used to cancel a bill, copy all the information into a new bill, and edit the new bill where necessary. The status of this new bill is ENTERED/NOT REVIEWED. This process prevents having to use the Enter/Edit Billing Information option to create a new bill which would require re-entry of all the data. Bills returned from Accounts Receivable with minor inconsistencies can quickly and easily be corrected through this option.

The Medical Care Cost Recovery data is arranged so that it may be viewed and edited through various screens. The data is grouped into sections for editing. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by brackets ([ ]) may be edited while those enclosed by arrows (< >) may not. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient), and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the data groups found on that screen and also provides the name and number of each available screen in the option.

SCREEN 1
DEMOGRAPHIC
INFORMATION

The Demographic Screen contains patient information such as date of birth, marital status, address, phone number, and whether or not the patient was service connected for any condition at the time the care on the bill was rendered. Much of this screen is automatically filled in from data in the PATIENT file.

SCREEN 2
EMPLOYMENT
INFORMATION

The Employment Screen lists the patient's employer and his/her employment status. Employment information concerning the patient's spouse may also be listed.

INTRODUCTION, cont.

SCREEN 3 PAYER INFORMATION	Screen 3 contains information regarding who is responsible for payment of the bill; patient, insurer or other. "Other" status may include another VA, a private hospital, etc. Please see the Data Supplement at the end of this option documentation for important information on how the bill mailing address is determined.
SCREEN 4 EVENT INPATIENT INFORMATION	The Event - Inpatient Information Screen contains such data elements as admission and discharge dates, principal diagnosis, prosthetics, procedures, occurrence codes, value codes, and condition codes. Screen 4 appears for inpatient bills only.
SCREEN 5 EVENT OUTPATIENT INFORMATION	The Event - Outpatient Information Screen displays data concerning diagnosis, coding method, outpatient procedure codes, occurrence, value and condition codes, prosthetics, and prescription refills. Screen 5 appears for outpatient bills only.
SCREEN 6 & 7 BILLING GENERAL INFORMATION	The Billing Screen will appear differently for inpatient (Screen 6) and outpatient (Screen 7) episodes. Both screens include bill from and to dates, charges, bill type, time frame, release of sensitive information, covered/non-covered charges, revenue codes and charges,and assignment of benefits.
SCREEN 8 BILLING SPECIFIC INFORMATION	For UB-92 forms, this screen contains the bill remark, treatment authorization code, admitting diagnosis, attending and other physicians, and those locators on the billing form which are unlabeled (locator 49 is uneditable). The UB-82 form excludes specific fields for the admitting diagnosis and physicians; however, they may be entered into the unlabeled form locators. For HCFA-1500 forms, this screen contains the unable to work from and to dates, Block 31 entry/edit, and treatment authorization code.

INTRODUCTION cont.

The CAN INITIATOR AUTHORIZE? site parameter and IB AUTHORIZE security key affect this option. Please see the Data Supplement found at the end of this option documentation for a description of this parameter and security key as well as a description of most of the fields found on the billing screens.

A mail group may be specified (through the site parameters) so that every time a bill is disapproved during the authorization phase of the billing process, or suspended during the generation phase, all members of this group are notified via electronic mail. If this group is not specified, only the billing supervisor, the initiator of the billing record, and the user who disapproved or generated the bill will be recipients of the message. Examples of messages may be found in the Enter/Edit Billing Information documentation. An explanation of how the bill mailing address field is determined is provided in the Data Supplement at the end of this option documentation.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which may be produced from this option. The data elements and design of both forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. Both must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the Print Bill option documentation.

Only holders of the IB AUTHORIZE security key may access this option.

The chart beginning on the following page shows the prompts and steps involved in using the Copy and Cancel option.

Third Party Billing Menu
Copy and Cancel

PROCESS

The following chart shows the prompts and steps involved in using the Copy and Cancel option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	If the patient name is entered, all bills for that patient will be listed for selection. Bills already cancelled may not be selected.		
1	Enter BILL NUMBER or PATIENT NAME:	.patient name .bill number .<RET>	2 2 15
2	ARE YOU SURE YOU WANT TO CANCEL THIS BILL? NO//	.<RET> or NO .YES	1 3
3	LAST CHANCE TO CHANGE YOUR MIND... CANCEL BILL?:	.NO .YES	1 4
4	REASON CANCELLED:	.reason (3-100 characters)	5
	Bill information is displayed with the following message.		
5	"Please verify the above information for the bill you just entered. Once this information is accepted it will no longer be editable and you will be required to CANCEL THE BILL if changes to this information are necessary." IS THE ABOVE INFORMATION CORRECT AS SHOWN? YES//	.<RET> or YES .NO	6 1
6	Numerous messages are displayed showing what actions are being taken by the software.		7

PROCESS, cont

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
7	The screens listed below may now be displayed individually for editing. The data on each screen is grouped into sections. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by ([ ]) may be edited while those enclosed by (< >) may not. A question mark <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN. A Data Supplement is included at the end of this option documentation providing an explanation of selected data fields found on the screens. For detailed documentation concerning editing, please see the Enter/Edit Billing Information option contained in this section of the manual. After editing, you will proceed to Step 8. I=inpatient bill screen O=outpatient bill screen B=both Screen 1 Demographic Information B Screen 2 Employment Information B Screen 3 Payer Information B Screen 4 Event-Inpatient Information I Screen 5 Event-Outpatient Information O Screen 6 Billing-General Information I Screen 7 Billing-General Information O Screen 8 Billing-Specific Information B The following prompt will appear at the bottom of each screen. <RET> to CONTINUE, 1-{#} to EDIT, '^N' for screen N, or '^' to QUIT: • <RET> at Screens 1 thru 7 will take you to the next appropriate screen. <RET> at Screen 8 will take you to Step 8. • Enter the field group number(s) you wish to edit using commas and dashes as delimiters. • Up-arrow <^> and the number of the screen you wish to see will take you to that screen. • Up-arrow <^> will return you to Step 1.		
	Any inconsistencies found in the bill are now listed. If there are no inconsistencies, you will proceed to Step 9. If you answer NO at this prompt, you will not be able to continue.		
8	Do you wish to edit inconsistencies now? NO//	.NO .YES	1 7

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
9	"No Errors found Entered: {DATE} by {NAME}" WANT TO EDIT SCREENS? NO//	.<RET> or NO .YES if you need to edit the screens	10 7
	** NOTE ** The appearance of some or all of the remaining prompts in this option is dependent on how certain site parameters are set and whether or not the user holds the required security key. See the Data Supplement for further explanation.		
10	WANT TO AUTHORIZE BILL AT THIS TIME? NO//	.<RET> or NO .YES	1 11
11	AUTHORIZE BILL GENERATION?:	.NO .YES	12 13
	This prompt will repeat until a <RET> is entered.		
12	Select REASON(S) DISAPPROVED-INITIAL:	.reason for disapproval .<??> for list of reasons .<RET>	12 12 1
13	"Passing completed Bill to Accounts Receivable. Bill is no longer editable. Completed Bill Successfully sent to Accounts Receivable. Entered: {DATE} by {NAME} Authorized: {DATE} by {NAME}" WANT TO PRINT BILL AT THIS TIME? NO//	.<RET> or NO .YES	1 14

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
14	You will be prompted for a device at this Step. The device prompt will appear with a default if one has been entered through the Select Default Device for Forms option for the type of form you are printing		1
15	Return to the menu.		

Third Party Billing Menu
Copy and Cancel

EXAMPLE
The following is an example of what might appear on the screen while using the Copy and Cancel option. User responses are shown in boldface type.

```
Enter BILL NUMBER or Patient NAME:  80042A        CARR,RALPH       12-09-43
   Outpatient     MEANS TEST/CAT. C      AUTHORIZED

ARE YOU SURE YOU WANT TO CANCEL THIS BILL? NO//  Y   (YES)

LAST CHANCE TO CHANGE YOUR MIND...
CANCEL BILL?:  Y   (YES)
REASON CANCELLED:  Diagnosis information missing

   ...Bill has been cancelled...

CARR,RALPH (111-22-1122)                                    DOB: DEC 9,1943
================================================================================
Rate Type    :  MEANS TEST/CAT. C
Event Date   :  NOV 16,1991
Sensitive    :  NO
Responsible  :  PATIENT

Bill Type    :  131
  o 1st Digit:  1 - HOSPITAL (INCLUDES CLINIC) - INPT. OR OPT.
  o 2nd Digit:  3 - OUTPATIENT
  o 3rd Digit:  1 - ADMIT THRU DISCHARGE CLAIM

Bill From    :  NOV 16,1991
Bill To      :  NOV 16,1991

Initial Bill#:  80042A
Copied Bill# :  80045A

Please verify the above information for the bill you just entered.
Once this information is accepted it will no longer be editable and
you will be required to CANCEL THE BILL if changes to this
information are necessary.

IS THE ABOVE INFORMATION CORRECT AS SHOWN? YES//  <RET>   (YES)
Passing bill to Accounts Receivable Module...
Billing Record #80045A being established for 'CARR,RALPH'...
Cross-referencing new billing entry...

Billing Record #80045A established for 'CARR,RALPH'...
```

EXAMPLE, cont.

```
CARR,RALPH    111-22-1122        BILL#  80045A - Outpatient         SCREEN <1>
================================================================================
                        DEMOGRAPHIC INFORMATION
[1] DOB    : 12-09-43
[2] Alias  : NO ALIAS ON FILE FOR THIS PATIENT
[3] Sex    : MALE                          Marital: MARRIED
[4] Veteran: YES                       Eligibility: NON-SERVICE CONNECTED

[5] Address: 67 SCARECROW LANE           Temporary: NO TEMPORARY ADDRESS
                 TROY, NY 12180
[6] Pt Short
    Address: 67 SCARECROW LANE,TROY,NY 12180

[7] SC Care: NO


<RET> to CONTINUE, 1-7 to EDIT, ^N for screen N, or '^' to QUIT:  ^5
Removing old Revenue Codes..
Updating Revenue Codes
          REV. CODE   UNITS    CHARGE       BEDSECTION
Adding      500         6      $   23.00    OUTPATIENT VISIT




CARR,RALPH    111-22-1122        BILL#  80045A - Outpatient         SCREEN <5>
================================================================================
                    EVENT - OUTPATIENT INFORMATION
<1> Event Date : NOV 16,1991
[2] Prin. Diag.: CARDIOGENIC SHOCK - 785.51
[3] OP Visits  : NOV 16,1991
[4] Cod. Method: UNSPECIFIED   [NOT REQUIRED]
[5] Rx. Refills: UNSPECIFIED   [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED   [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED   [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED   [NOT REQUIRED]
[9] Value Code : UNSPECIFIED   [NOT REQUIRED]


<RET> to CONTINUE, 1-9 to EDIT, ^N for screen N, or '^' to QUIT:  3,4


                              <<<OUTPATIENT VISITS>>>

================================================================================
NO.    VISIT DATE      ELIG/MT     CPT   CHARGE   BILL# - TYPE    STOP CODE
===    ==========      =======     ===   ======   ============    ===========
 1)    NOV 16, 1991    NSC/N        Y    $50.00                   CARDIOLOGY
```

EXAMPLE, cont.

```
SELECT VISITS TO BE INCLUDED IN THIS BILL:  1
YOU HAVE SELECTED VISIT(S) NUMBERED- 1
IS THIS CORRECT? YES//  <RET>   (YES)


                    <<CURRENT PROCEDURAL TERMINOLOGY CODES>>

               LISTING FROM VISIT DATES WITH ASSOCIATED CPT CODES
                           IN SCHEDULING VISITS FILE

================================================================================
NO.   CODE           SHORT NAME                          PROCEDURE DATE
================================================================================
1)    93015          CARDIOVASCULAR STRESS TEST          NOV 16, 1991



SELECT CPT CODE(S) TO INCLUDE IN THIS BILL: 1
YOU HAVE SELECTED CPT CODE(S) NUMBERED-1
IS THIS CORRECT? YES// <RET>  (YES)
    Adding CPT Procedure: 93015
Select OP VISITS DATE(S): NOV 16,1991// <RET>
PROCEDURE CODING METHOD: CPT-4// <RET>
Select PROCEDURE DATE: <RET>



<<< NOTE: Screen 5 is redisplayed with the new values.>>>

CARR,RALPH    111-22-1122        BILL#  80045A - Outpatient         SCREEN <5>
================================================================================
                  EVENT - OUTPATIENT INFORMATION
<1> Event Date : NOV 16,1991
[2] Prin. Diag.: CARDIOGENIC SHOCK - 785.51
[3] OP Visits  : NOV 16,1991
[4] Cod. Method: CPT-4
    CPT Code   : CARDIOVASCULAR STRESS TEST - 93015  DATE: NOV 16,1991
[5] Rx. Refills: UNSPECIFIED   [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED   [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED   [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED   [NOT REQUIRED]
[9] Value Code : UNSPECIFIED   [NOT REQUIRED]


<RET> to CONTINUE, 1-9 to EDIT, ^N for screen N, or '^' to QUIT:  ^8
```

EXAMPLE, cont.

```
CARR,RALPH    111-22-1122        BILL#  80045A - Outpatient         SCREEN <8>
================================================================================
                    BILLING - SPECIFIC INFORMATION
[1] Bill Remark     : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code   : UNSPECIFIED [NOT REQUIRED]
    Admitting Dx    : UNSPECIFIED [NOT REQUIRED]
[2] Attending Phy.  : UNSPECIFIED [NOT REQUIRED]
    Other Physician : UNSPECIFIED [NOT REQUIRED]
[3] Form Locator 2  : UNSPECIFIED [NOT REQUIRED]
    Form Locator 11 : UNSPECIFIED [NOT REQUIRED]
[4] Form Locator 31 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 37 : UNSPECIFIED [NOT REQUIRED]
[5] Form Locator 56 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 57 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 78 : UNSPECIFIED [NOT REQUIRED]

<RET> to QUIT, 1-5 to EDIT, ^N for screen N, or '^' to QUIT:  <RET>


No Errors found

Entered       : DEC 13,1991 by PENNY,JOSEPH

WANT TO EDIT SCREENS? NO//  <RET>   (NO)

WANT TO AUTHORIZE BILL AT THIS TIME? NO//  Y   (YES)
AUTHORIZE BILL GENERATION?:  Y   (YES)
Passing completed Bill to Accounts Receivable.  Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.

Entered        : DEC 13, 1991 by PENNY,JOSEPH
Authorized     : DEC 13, 1991 by PENNY,JOSEPH

WANT TO PRINT BILL AT THIS TIME? NO//  Y   (YES)
Output Device: A200//  <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO//  <RET>
```

Third Party Billing Menu
Copy and Cancel

DATA SUPPLEMENT
This section is provided to give further clarification to the following elements which appear in the Copy and Cancel option.

Fields	Explanation of select fields (data items) found in this option.
Parameters and Security Keys	Explanation of select parameters and security keys which affect the functioning of this option.
Billing Mailing Address	Explanation of how the billing mailing address is determined.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
1	Patient Short Mailing Address	Abbreviated patient mailing address (if necessary). Address cannot exceed 47 characters for billing form.
1	SC at Time of Care	Was this patient service connected for any condition at the time the care in the bill was rendered. This field is used to correctly assign Accounts Receivable AMIS segments to this bill if it is a Reimbursable Insurance bill. The default for this field is the current value in the SC PATIENT field of the PATIENT file. If this field is left blank, the default value will be used to determine the AMIS segment.
3	Institution Name	When payer is "other", name of institution responsible for payment of bill (i.e., other VAMC, federal agency, private hospital).

DATA SUPPLEMENT, cont.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
3	Form Type	The type of form the bill is printed on. If the MULTIPLE FORM TYPES parameter is set to YES, this field will appear.
3	Primary/Secondary/ Tertiary Provider	The number assigned to the provider by the primary/secondary/tertiary payer.
4	Admission	Date of admission for inpatient bill (event date).
4	Source of Admission	Source of this patient admission; i.e., clinic referral.
4	Type of Admission	EMERGENCY - Used for emergency admissions. URGENT - Used for routine admissions. ELECTIVE - Cosmetic surgery, etc. (should not be used routinely).
4	Accident Hour	Time of accident or injury (to be used only with episodes of care resulting from an accident).
4	Discharge Status	Patient status at time of discharge; i.e., expired, left against medical advice.
4	Principal Diagnosis	Code of diagnosis responsible for patient's greatest length of stay for this inpatient hospital episode. Automatically filled in from PTF record, if available.
4	Principal Procedure	Principal surgery or procedure occurring during this inpatient hospital episode (if any). Automatically filled in from PTF record, if available.

DATA SUPPLEMENT, cont.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
4	Procedure Coding Method	Coding method used for procedure/surgery coding. The choices are CPT-4, HCPCS, or ICD-9-CM.
4, 5	Occurrence Code	Event relating to bill that may affect insurance processing (if applicable). Some codes relate to a single date while others relate to a date range.
4, 5	Condition Code	Condition relating to patient that may affect insurance processing (if applicable).
4, 5	Value Code	This code relates amounts or values to identified data elements necessary to process the claim as qualified.
4, 5	Order	This is the print order in which the procedures/diagnoses will appear on the form. The six lowest procedure and nine lowest diagnosis numbers will appear on the form in the boxes, the rest will print as additional procedures/diagnoses. If no print order is specified, the procedures/diagnoses will print in the order entered.
4, 5	Place of Service	Used in Block 24C of the HCFA-1500 form indicating where the procedure was provided.
4, 5	Type of Service	Used in Block 24D of the HCFA-1500 billing form indicating what kind of medical care was provided for this procedure.
4, 5	State	If the treatment is related to an automobile accident, this field is used to specify the location on the HCFA-1500 form.

DATA SUPPLEMENT, cont.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
5	Event Date	Outpatient bill (only one visit) - date of visit. Outpatient bill (multiple visits) - date of initial visit.
5	Associated Clinic	The clinic where the procedure was performed. This field must be completed for this procedure to be successfully transferred to the Add/Edit Stop code logic for inclusion in OPC workload.
5	Associated Diagnosis	This is the diagnosis for the procedure being performed. An associated diagnosis (up to 4) must be entered for each procedure when using the HCFA-1500 form. It must match one of the first four diagnoses entered.
5	Division	A division must be entered for all BASC procedures. This is required for the charge calculation.
5	Opt. Code	Code name/number for outpatient procedure/surgery performed. Bypass if no procedures/surgeries performed.
5, 7	OP Visits	Multiple field for outpatient bills. For facilities that bill more than one visit per bill, field where the facility can specify all the outpatient visit dates being billed (up to 30 per bill).
6	Discharge Bedsection	Patient's bedsection at time of discharge.
6	Length of Stay	Length of stay in days. Excludes the discharge date of all bills that are not interim first or interim continuous.

DATA SUPPLEMENT, cont.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
6, 7	Revenue Code	Code which identifies a specific accommodation, ancillary service, or billing calculation. May enter up to 10 active codes per bill. You may add codes for a patient from the list provided, but cannot add new codes to the list.
6, 7	Charges	Cost of 1 unit of service; i.e., 1 inpatient day, 1 outpatient visit.
6, 7	Units of Service	Number of units of service rendered to this patient for a specific revenue code.
6, 7	Offset Amount	Dollar amount that is to be subtracted from the total charges on this bill; i.e., copayments, deductibles.
6, 7	Bill Total	Units of service (x) charges for all Revenue codes.
6, 7	Statement Covers From	Statement covers services rendered from this date. Use event date if billing from admission through discharge or if billing for opt. services. Use beginning date of services covered by bill for interim billing. Interim inpatient bills should no longer overlap.
6, 7	Statement Covers To	Statement covers services rendered to this date. Use discharge date if billing from admission through discharge. Use date of last opt. visit for outpatient bills. Use ending date of services covered by bill for interim bills. Interim inpatient bills should no longer overlap.

DATA SUPPLEMENT, cont.

FIELDS

SCREEN	FIELD NAME	DESCRIPTION
6, 7	R.O.I. Form(s) Completed	Release of Information form completed or not completed.
6, 7	Assignment of Benefits	Will automatically be set to YES when entering a third party bill and will not be editable.
6, 7	Power of Attorney	Have Power of Attorney forms been signed? Will only appear if occurrence codes selected pertain to an accident.
6, 7	FY 1	Will be automatically set to fiscal year of event date and FY1 charges will equal bill total (offset not deducted).
6, 7	Procedure	Associates a particular revenue code charge with a specific CPT procedure on the HCFA-1500 form.
6, 7	Covered/Non-Covered Days	Number of days covered/not covered by the primary payer.
8	Bill Comment	Remarks associated with this bill which will print on the UB-82/92 form (2-35 characters).
8	Form Locator fields	Unlabeled fields on UB-82/92 form. Use may be determined at the state or national level after negotiations between payers and providers.
8	Treatment Authorization Code	Number or other indicator that designates that the treatment covered by this bill has been authorized by the payer.

DATA SUPPLEMENT, cont.

PARAMETERS

1. CAN INITIATOR REVIEW?	If set to YES, user who entered billing data may review bill (if required security keys held). If this parameter is set to NO, the initiator of the bill will not be allowed to review it.
1. CAN REVIEWER AUTHORIZE?	If set to YES, user who reviewed bill can authorize generation of billing form (if required security keys held). If this parameter is set to NO, the reviewer of the bill will not be allowed to authorize its generation.
3. CAN CLERK ENTER NON-PTF CODES	If set to YES, user will be allowed to enter diagnosis and procedure codes not found in the PTF record into the billing record. User will also be able to select ICD-9-CM, CPT-4, or HCPCS as the procedure coding method and can enter CPT or ICD procedure codes into the billing record, if desired. If this parameter is set to NO, the user will be able to enter into the billing record only those diagnosis and procedure codes found in the PTF record associated with the episode of care being billed.

DATA SUPPLEMENT, cont.

SECURITY KEY

IB AUTHORIZE	Allows the holder to authorize generation of all bill form types.

BILL MAILING ADDRESS

The following is an explanation of how the bill mailing address field on Screen 3 is determined.

WHO'S RESPONSIBLE	BILL MAILING ADDRESS IS
Patient	Patient's mailing address
Institution	
Institution has not been selected	Patient's mailing address
Institution has been selected	Institution's mailing address
Insurer	
Patient has no insurance company on file or more than one insurance company with none selected	No mailing address stored
Primary insurance company selected and bill is for inpatient stay and another company does not process the primary insurance company's inpatient claims	Primary insurance company's inpatient claims processing address
Primary insurance company selected and bill is for outpatient visit and another company does not process the primary insurance company's outpatient claims	Primary insurance company's outpatient claims processing address
Primary insurance company selected and bill is for inpatient stay and another company processes the primary insurance company's inpatient claims	Inpatient claims processing address of the company that processes the primary insurance company's inpatient claims

DATA SUPPLEMENT, cont.

BILL MAILING ADDRESS

WHO'S RESPONSIBLE	BILL MAILING ADDRESS IS
Insurer, cont.	
Primary insurance company selected and bill is for outpatient visit and another company processes the primary insurance company's outpatient claims	Outpatient claims processing address of the company that processes the primary insurance company's outpatient claims
Primary insurance company selected and the insured's employer should receive the insurance claims for pre-processing	Employer's claims processing address

If the mailing address is edited at any time, the edited address is stored. If a new rate type or insurance company is selected at any time, even if the mailing address has been edited, the mailing address will be determined as described above.

Third Party Billing Menu
Delete Auto Biller Results

INTRODUCTION

This option is used to delete entries from the Automated Biller Errors/Comments report prior to a user-selected date for any entry not associated with a bill.

The auto biller checks a variety of data elements concerning an event before a bill is created. The auto biller will only create reimbursable insurance bills, so the patient must be a veteran with active insurance. The disposition prior to the event date is checked and if the need for care was related to an accident or the veteran's occupation, the auto biller will not create a bill. Since dental is usually billed separately, any event with a dental clinic stop will also be excluded. The auto biller also checks to ensure that the event has not already been billed.

Entries are removed from the Automated Biller Errors/ Comments report in two ways. If a bill was created for the event, the bill's entry is removed from the report when the bill is either printed or cancelled. If a bill was not created, this option must be used to delete the entry.

You will be prompted for a date. The default value provided is three days previous to the current date.

Due to the brevity of this option, a process chart is not provided.

Third Party Billing Menu
Delete Auto Biller Results

EXAMPLE
The following example shows what might appear on your screen while using this option. User responses appear in boldface type.

```
Select Third Party Billing Menu Option: Delete Auto Biller Results
End Date for Delete: Dec 24, 1993// <RET>

  (DEC 24, 1993).............................
.........
```

Third Party Billing Menu
Print Bill

Updates to HCFA-1500 form -
It is now possible to charge the same CPT different dollar amounts on the same bill.

If the same CPT has been added to the bill more than once and one or neither of them has a print order, they will be combined as a single line item on the bill.

Block 28 now contains the total charges reported in block 24. Block 29 contains the total of the primary, secondary, and tertiary payments. Block 30 contains the difference between block 28 and block 29.

Updates to UB-92 form -
If a charge is printed for a procedure with a modifier, the modifier will be printed with the CPT in Block 44.

Form Locator 48 now contains the contents of the non-covered charges field for a revenue code.

The bill number on both the HCFA-1500 (Block 26) and the UB-92 (Form Locator 3) are now the AR bill number, including the station number.

Introduction

The Print Bill option is used to print third party bills on the appropriate form (UB-82/92 or HCFA-1500) after all required information has been input and the billing record has been authorized. You may also reprint a previously printed bill.

A final review of the information in the billing record may be performed through this option. The data is arranged so that it may be viewed through various screens. The patient's name, social security number, bill number, the bill classification (Inpatient or Outpatient), and the screen number appear at the top of every screen. A <?> entered at the prompt which appears at the bottom of each screen will provide you with a HELP SCREEN for that particular screen. The HELP SCREEN lists the name and number of each available screen for the bill you are working on and the data groups for that particular screen.

Introduction, cont.

No editing of the data is allowed in this option. Data can be edited through the Enter/Edit Billing Information option, if necessary.

The UB-82, UB-92, and HCFA-1500 billing forms are the output which may be produced from this option. The data elements and design of these forms has been determined by the National Uniform Billing Committee and has been adapted to meet the specific needs of the Department of Veterans Affairs. They must be generated (printed) at 80 characters per line at 10 pitch. Copies of the billing forms are included in the example portion of this option documentation.

Example

```
Enter BILL NUMBER or PATIENT NAME:  BAILEY,GEORGE B   12-09-50   123456765
SC VETERAN

  1   JUN 1,1997      L10342   REIM INS-Opt     ENTERED/NOT REVIEWED

CHOOSE 1:  1

Entered        : JUN  2, 1997 by HOUSER,DOUGLAS
Authorized     : JUN 11, 1997 by CASEY,BENJAMIN

WANT TO REVIEW SCREENS? NO//  <RET>   (NO)

WANT TO PRINT BILL AT THIS TIME? NO//  Y    (YES)

Output Device: A200//  <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO//  Y   (YES)

Requested Start Time: NOW//  <RET>   (JUN 12,1997@13:49)
```

EXAMPLE, cont.

Sample of UB-82 bill

EXAMPLE, cont.

Sample of UB-92 bill

Third Party Billing Menu
Print Bill

EXAMPLE, cont.

Sample of HCFA-1500 bill

EXAMPLE, cont.

Sample of HCFA-1500 bill, cont.

```
BILL ADDENDUM FOR DOE,JOHN - L00979                              JAN 28, 1994  15:26   PAGE 1
-------------------------------------------------------------------------------------------------


PRESCRIPTION REFILLS:

481     Dec 01, 1993     DIGOXIN 0.25MG         QTY: 60     DAYS SUPPLY: 30     NDC #: 19-929-922
432     Dec 01, 1993     NAPROXEX 250MG S.T.    QTY: 10     DAYS SUPPLY: 10     NDC #: 22-834-871
```

Third Party Billing Menu
Patient Billing Inquiry

INTRODUCTION

The Patient Billing Inquiry option allows you to display/print information on any reimbursable insurance bill, pharmacy copay, or Means Test bill. The information provided differs depending on the bill type.

For reimbursable insurance bills, the information provided includes bill status, rate type, reason cancelled (if applicable), admission date (for inpatients), all outpatient visits (for outpatients), charges, amount paid, statement to and from dates, each action that was taken on that bill, and the user who performed it. If you choose to view the full inquiry, address information from the PATIENT file and the bill is also provided.

The information provided in a brief inquiry for Pharmacy Copay charges includes date of charge, type of charge (syntax: patient eligibility - action type - status), brief description (syntax: prescription # - drug name - # of units), amount of charge or credit, and an explanation of any charge removed, if applicable. A full inquiry, in addition to the information provided in the brief inquiry, provides information from the PRESCRIPTION file, as well as address information on the patient.

The display/output for Means Test bills is very similar to the brief inquiry for Pharmacy Copay. It includes the date of charge, charge type, brief description, units, and amount of charge. A full inquiry also includes address information on the patient.

Due to the brevity of this option, no process chart is provided.

EXAMPLE

The following is an example of what might appear on the screen while using the Patient Billing Inquiry option. User responses are shown in boldface type. Sample outputs are provided beginning on the following page.

```
Select CHARGE ID or PATIENT NAME: L10008   500-L10008   C (MEANS TEST)  02-07-
92    ALLEN,JOHN A     OPEN  $628.00
(B)rief or (F)ull Inquiry: B// FULL

Output Device: HOME// A137  LASER PRINTER   RIGHT MARGIN: 80// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// <RET>  (NO)

Select CHARGE ID or PATIENT NAME:
```

EXAMPLE, cont.

EXAMPLE 1 - Full inquiry for a reimbursable insurance bill.

```
ALLEN,JOHN A    442-12-1211       500-000303    FEB 19, 1992@14:17     PAGE: 1
================================================================================
Bill Status    : PRINTED - RECORD IS UNEDITABLE
Rate Type      : REIMBURSABLE INSURANCE

Op Visit dates : APR 14,1992

Charges        :  $148.00
LESS Offset    :   $30.00
Bill Total     :  $118.00

Statement From : APR 14,1992
Statement To   : APR 14,1992

Entered        : APR 15, 1992 by CORCHRAN,EDWARD
First Reviewed : APR 16, 1992 by MIX,SUE
Last Reviewed  : APR 16, 1992 by MIX,SUE
Authorized     : APR 16, 1992 by MIX,SUE
Last Printed   : APR 16, 1992 by HOOPER,GARY
```

```
ALLEN,JOHN A    442-12-1211       500-000303    FEB 19, 1992@14:17     PAGE: 2
================================================================================

*** ADDRESS INFORMATION ***

Patient Address:  117 ALLEN DRIVE
                  COLONIE, NEW YORK
                  518-786-0990

Mailing Address:  AETNA
                  1262 MOONBEAM AVENUE
                  LOS ANGELES, CALIFORNIA   12345

Ins Co. Address:  AETNA
                  1262 MOONBEAM AVENUE
                  LOS ANGELES, CALIFORNIA   12345
                  618-567-5555
```

EXAMPLE, cont.

EXAMPLE 2 - Full inquiry for a Means Test bill.

```
DENNIS,JOHN   436-88-2965          500-L10098   FEB 24, 1992@09:09   PAGE: 1
================================================================================
FEB 14, 1992   INPT COPAY (MED) NEW  INPT CO-PAY (MED)         1      $200.00
FEB 20, 1992   INPT COPAY (MED) CAN  INPT CO-PAY (MED)         1     ($200.00)
     Charge Removal Reason: MT CHARGE EDITED
                                                                   ------------
                                                                         $0.00
```

```
DENNIS,JOHN   436-88-2965          500-L10098   FEB 24, 1992@09:09   PAGE: 2
================================================================================

                         *** ADDRESS INFORMATION ***

Patient Address:  28 TURNIPFIELD RD
                  EASTHAM, MASSACHUSETTS
                  508-321-4321
```

EXAMPLE 3 - Brief inquiry for a Pharmacy Copay bill.

```
KAGAN,PETER    442-12-1211         500-M10004   FEB 24, 1992@09:18   PAGE: 1
DATE           CHARGE TYPE          BRIEF DESCRIPTION        UNITS      CHARGE
================================================================================
MAR 15, 1991   SC RX COPAY NEW       RX#111128-REF 5-ENDU       3        $6.00
MAR 15, 1991   SC RX COPAY NEW       RX#111199 9999-CLONI       4        $8.00
                                                                   ------------
                                                                         $14.00
```

Third Party Billing Menu
Print Auto Biller Results

INTRODUCTION

This option is used to print the Automated Biller Errors/ Comments report. The results of the execution of the auto biller are listed on this report. For Claims Tracking events for which the auto biller attempted to create a bill, this report will list either the reason a bill was not created or the bill number and any comments on the bill.

The auto biller checks a variety of data elements concerning an event before a bill is created. The auto biller will only create reimbursable insurance bills, so the patient must be a veteran with active insurance. The disposition prior to the event date is checked and if the need for care was related to an accident or the veteran's occupation, the auto biller will not create a bill. Since dental is usually billed separately, any event with a dental clinic stop will also be excluded. The auto biller also checks to ensure that the event has not already been billed.

Entries are removed from the Automated Biller Errors/ Comments report in two ways. If a bill was created for the event, the bill's entry is removed from the report when the bill is either printed or cancelled. If a bill was not created, the Delete Auto Biller Results option must be used to delete the entry.

The bills will be grouped on the output by the date entered. The following information may appear on the report: patient name, event type, episode date, bill number, bill status, timeframe of bill, and statement covers from and to dates. Comments relating to individual bills may also be provided.

You will be prompted for a date range, a patient range, and a device.

Due to the brevity of this option, a process chart is not provided.

Third Party Billing Menu
Print Auto Biller Results

EXAMPLE
The following example shows what might appear on your screen while using this option followed by a sample output. User responses appear in boldface type.

```
Report requires 132 columns.
START WITH DATE ENTERED: 11 1 93
GO TO DATE ENTERED: TODAY// 11 10 93
    START WITH CLAIMS TRACKING PATIENT: FIRST// <RET>
DEVICE: A200    RIGHT MARGIN: 132// <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO// Y  (YES)

REQUESTED TIME TO PRINT: NOW// <RET>
REQUEST QUEUED!
Task number: 13515
```

```
AUTOMATED BILLER ERRORS/COMMENTS FOR Nov 1, 1993 - Nov 10, 1993                    DEC 10,1993  13:19    PAGE 1
                              EVENT                          BILL                  TIMEFRAME OF        STATEMENT     STATEMENT
PATIENT                       TYPE   EPISODE DATE            NUMBER    STATUS      BILL                COVERS FROM   COVERS TO
-------------------------------------------------------------------------------------------------------------------------------

       DATE ENTERED: NOV  1,1993

BOOK,JOHN             B6711   INPA   SEP  1,1993  17:07     N10003    ENTERED     INTERIM - FIRST     SEP  1,1993   SEP 30,1993
CANNEDY,CARLE JR.     C4949   INPA   SEP  1,1993  01:00     N10005    ENTERED     INTERIM - FIRST     SEP  1,1993   SEP 30,1993
DERDERIAN,TONY L      D1250   INPA   OCT  3,1993  22:10     N10004    ENTERED     ADMIT THRU DISC     OCT  3,1993   OCT  6,1993
DERDERIAN,CARL T      D8888   INPA   SEP 20,1993  13:09     N10007    ENTERED     INTERIM - FIRST     SEP 20,1993   SEP 30,1993
KILMADE,MICHAEL J     K2123   INPA   SEP 14,1993  11:42     N10002    ENTERED     ADMIT THRU DISC     SEP 14,1993   SEP 14,1993
                                     No billable Days.
SMITH,MIKE            S7689   INPA   SEP 16,1993  15:56     N10006    ENTERED     ADMIT THRU DISC     SEP 16,1993   SEP 16,1993
                                     No billable Days.
LEE,DANNY             Z6789   INPA   SEP 14,1993  23:01     N10001    ENTERED     ADMIT THRU DISC     SEP 14,1993   SEP 15,1993

BACALL,HUMPHREY       B0540   OUTP   OCT  8,1993  08:00     N10009    ENTERED     ADMIT THRU DISC     OCT  8,1993   OCT  8,1993
DANE,DONALD           D3456   OUTP   SEP 28,1993  18:20     N10008    ENTERED     ADMIT THRU DISC     SEP 28,1993   SEP 28,1993
EVERETT,MARGARET W    E6655   OUTP   OCT 22,1993  12:00     N10017    ENTERED     ADMIT THRU DISC     OCT 22,1993   OCT 22,1993
EVERETT,MARGARET W    E6655   OUTP   OCT 22,1993  12:30     N10017    ENTERED     ADMIT THRU DISC     OCT 22,1993   OCT 22,1993
ROBERTSON,ALONZO      R2222   OUTP   OCT 22,1993  08:00     N10016    ENTERED     ADMIT THRU DISC     OCT 22,1993   OCT 22,1993
SKINNER,ALAN A        S1211   OUTP   AUG 15,1993              N10010    ENTERED     ADMIT THRU DISC     AUG 15,1993   AUG 17,1993
SKINNER,ALAN A        S1211   OUTP   AUG 17,1993              N10010    ENTERED     ADMIT THRU DISC     AUG 15,1993   AUG 17,1993
SRAY,PETER            S0707   OUTP   SEP 28,1993  08:00     N10018    ENTERED     ADMIT THRU DISC     SEP 28,1993   SEP 28,1993
SRAY,PETER            S0707   OUTP   OCT  1,1993  08:00     N10019    ENTERED     ADMIT THRU DISC     OCT  1,1993   OCT  1,1993
SRAY,PETER            S0707   OUTP   OCT  1,1993  08:00     N10019    ENTERED     ADMIT THRU DISC     OCT  1,1993   OCT  1,1993
VANNONE,HARRY         V8591   OUTP   OCT  5,1993  11:10     N10020    ENTERED     ADMIT THRU DISC     OCT  5,1993   OCT  5,1993
VANNONE,HARRY         V8591   OUTP   OCT  5,1993  11:34     N10020    ENTERED     ADMIT THRU DISC     OCT  5,1993   OCT  5,1993

EAGLETON,GARRY        D3035   PRES   SEP  9,1993              N10021    ENTERED     ADMIT THRU DISC     SEP  9,1993   SEP  9,1993


       DATE ENTERED: NOV  2,1993

DERDERIAN,CARL T      D8888   INPA   SEP 20,1993  13:09     N10022    ENTERED     INTERIM - LAST      OCT  1,1993   OCT  5,1993


       DATE ENTERED: NOV  3,1993

BOOK,JOHN             B6711   INPA   SEP  1,1993  17:07     N10023    ENTERED     INTERIM - CONTI     OCT  1,1993   OCT 31,1993
CANNEDY,CARLE JR.     C4949   INPA   SEP  1,1993  01:00     N10025    ENTERED     INTERIM - CONTI     OCT  1,1993   OCT 31,1993
DAVIDESON,PAUL O      D1827   INPA   OCT 13,1993  14:12     N10024    ENTERED     INTERIM - FIRST     OCT 13,1993   OCT 31,1993


       DATE ENTERED: NOV  8,1993

BAKERIAN,MARK         D3333   INPA   SEP 15,1993  12:30     N10027    ENTERED     INTERIM - CONTI     OCT  1,1993   OCT 31,1993
```

Third Party Billing Menu
Print Authorized Bills

INTRODUCTION

The Print Authorized Bills option will print all bills with a status of AUTHORIZED in a user-specified order. The bills may be sorted by zip code, insurance company name, and patient name.

You may enter <??> at the "Begin printing bills?" prompt to see a list of all the bills which will print when this option is utilized. The list will show bill number, patient name, event date, inpatient or outpatient bill, bill type, bill status (AUTHORIZED), and bill form type. If this list is quite lengthy, you may wish to queue the output to print during off hours.

You are not prompted for a device in this option. Each bill form type will print on the billing default printer specified for it through the Select Default Device for Forms option on the System Manager's Integrated Billing Menu. Any form type not set up there will not print when utilizing this option.

The process chart on the following page shows the steps and prompts involved in using the Print Authorized Bills option.

Third Party Billing Menu
Print Authorized Bills

PROCESS

The following chart shows the prompts and steps involved in using the Print Authorized Bills option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
1	First Sort Bills By: (Z/I/P):	.Z for zip code	2
		.I for insurance company	2
		.P for patient name	2
		.<RET>	5
	You will proceed to Step 3 after the third sort choice is entered.		
2	Then Sort Bills By: (Z/I/P):	.another sort choice	2
		.<RET>	3
3	Begin printing bills?	.YES	4
		.NO	5
		.<??> for a list of all the bills which will print	3
4	Requested Start Time: NOW//	.<RET> for printing to begin now	5
		.date@time to start printing	5
5	Return to the menu.		

EXAMPLE

The following example shows what might appear on your screen while using the Print Authorized Bills option. User responses appear in boldface type. The output produced by this option is the authorized bills. An example of each of the bill form types can be found in the Example section of the Print Bill option located on this menu.

```
First Sort Bills By:  (Z/I/P): PATIENT NAME
Then Sort Bills By:  (Z/I/P): INSURANCE COMPANY NAME
Then Sort Bills By:  (Z/I/P): ZIP

Begin printing bills? ??

920604    KHAN,MARY-JO E        12/21/93  INPT   MT/CAT C  AUTHORI  UB-92
920605    PETERSON,MICHAEL      12/21/93  INPT   HUMAN     AUTHORI  UB-92
92081A    CURLEY,WILLIAM        11/09/93  OUTPT  HUMAN     AUTHORI  UB-92
92086A    LEETCH,MARK           11/22/93  OUTPT  REIM INS  AUTHORI  UB-92
92077B    QUINLAN,MARTIN        10/03/93  OUTPT  CRIME     AUTHORI  UB-92
000291    QUANDT,MARGE          12/07/93  INPT   MT/CAT C  AUTHORI  UB-92
000194    CHARLES,DOROTHY       11/07/93  INPT   MT/CAT C  AUTHORI  UB-92
L10020    ELLIOTT,JOHN          01/05/94  OUTPT  DENTAL    AUTHORI  UB-92
L10022    JOHNSON,PAUL          10/23/93  INPT   MT/CAT C  AUTHORI  UB-92
L10023    SKINNER,ALAN A        01/03/94  OUTPT  REIM INS  AUTHORI  HCFA 1500
Press RETURN to continue or '^' to exit: ^

Begin printing bills? Y  YES

Requested Start Time: NOW// <RET>    (JAN 28, 1994@13:32:06)
```

Third Party Billing Menu
Return Bill Menu
Edit Returned Bill

INTRODUCTION

The Edit Returned Bill option is used to correct bills with a status of RETURNED FROM AR (NEW) which have been returned to MAS from Accounts Receivable. You should generate the returned bill report through the Returned Bill List option before utilizing this option. That report contains a listing of all bills which have been returned to MAS providing the reason returned for each. This information is required to make the appropriate corrections to each bill. The bill number appears on that report preceded by the station number. The station number should not be entered when selecting the bill for editing.

After editing, the option allows you to return the bill to Accounts Receivable and print the bill if the required security key is held. It should be noted that returned bills with a status of RETURNED FOR AMENDMENT cannot be edited through this option and must be corrected through the Copy and Cancel option.

Only holders of the IB EDIT security key may access this option.

The chart beginning on the following page shows the prompts and steps involved in using the Edit Returned Bill option.

Third Party Billing Menu
Return Bill Menu
Edit Returned Bill

PROCESS
The following chart shows the prompts and steps involved in using the Edit Returned Bill option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	Only bills returned from Accounts Receivable may be selected. If the patient name or event date is entered, all applicable bills for that patient or with that event date will be listed for selection.		
1	Select BILL/CLAIMS BILL NUMBER:	.patient name	2
		.event date	2
		.bill number	2
		.<RET> or up-arrow <^>	10

2 The screens listed below may now be displayed individually for editing. The data on each screen is grouped into sections. Each section is labeled with a number to the left of the data items. Data group numbers enclosed by ([ ]) may be edited while those enclosed by (< >) may not. A question mark <?> entered at the prompt which appears at the bottom of every screen will provide you with a HELP SCREEN. For detailed documentation concerning editing, please see the Enter/Edit Billing Information option contained in this section of the manual. After editing, you will proceed to Step 3.

I=inpatient bill screen O=outpatient bill screen B=both

Screen 1	Demographic Information	B
Screen 2	Employment Information	B
Screen 3	Payer Information	B
Screen 4	Event-Inpatient Information	I
Screen 5	Event-Outpatient Information	O
Screen 6	Billing-General Information	I
Screen 7	Billing-General Information	O
Screen 8	Billing-Specific Information	B

The following prompt will appear at the bottom of each screen.

<RET> to CONTINUE, 1-{#} to EDIT, '^N' for screen N, or '^' to QUIT:

- <RET> at Screens 1 through 7 will take you to the next appropriate screen.
  <RET> at Screen 8 will take you to Step 3.
- Enter the field group number(s) you wish to edit.
- Up-arrow <^> and screen number you wish to see will take you to that screen.
- Up-arrow <^> will return you to Step 1.

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	The "Last Printed" line will only appear where applicable.		
3	"No Errors found Entered : {DATE} by {NAME} Authorized : {DATE} by {NAME} Last Printed : {DATE} by {NAME}"		
	WANT TO EDIT SCREENS? NO//	.<RET> or NO .YES	4 2
	You must hold the IB AUTHORIZE security key to return the bill to Accounts Receivable.		
4	WANT TO RETURN BILL TO AR AT THIS TIME? NO//	.<RET> or NO .YES	1 5
5	RETURNED COMMENTS:	.comments (3-80 characters) .<RET> to leave blank	6 6
6	RETURN TO A/R?	.YES .NO	7 1
	The "Last Printed" line will only appear where applicable.		
7	"Passing completed Bill to Accounts Receivable. Bill is no longer editable. Completed Bill Successfully sent to Accounts Receivable. Entered : {DATE} by {NAME} Authorized : {DATE} by {NAME} Last Printed : {DATE} by {NAME} Returned to AR : {DATE} by {NAME}"		
	WANT TO {PRINT/REPRINT} BILL AT THIS TIME? NO//	.<RET> or NO .YES	1 8

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	You may choose to reprint the bill with the following headings. "***SECOND NOTICE***" or "***THIRD NOTICE***" "*** COPY OF ORIGINAL BILL ***" will appear at the top of the reprinted bill if (C)OPY is entered. Selecting ORIGINAL at this prompt will allow reprinting of the bill without that heading. This should only be used when the original bill did not print correctly and has been destroyed.		
8	(2)nd Notice, (3)rd Notice, (C)opy or (O)riginal: C//	.2 for second notice bill .3 for third notice bill .C for copy of bill .O for original bill	9 9 9 9
9	You will be prompted for a device at this Step. The device prompt will appear with a default if one has been entered through the Select Default Device for Forms option for the type of form you are printing.		1
10	Return to the menu.		

Third Party Billing Menu
Return Bill Menu
Edit Returned Bill

EXAMPLE
The following is an example of what might appear on the screen while using the Edit Returned Bill option. User responses are shown in boldface type.

```
Select BILL/CLAIMS BILL NUMBER:  90014A   STRAIT,SAM   01-18-90   MEANS
TEST/CAT C   PRINTED


STRAIT,SAM   321-123-321    BILL#: 90014A - Outpatient              SCREEN <1>
==============================================================================
                            DEMOGRAPHIC INFORMATION
[1] DOB    : OCT 31,1949
[2] Alias  : NO ALIAS ON FILE FOR THIS PATIENT
[3] Sex    : MALE                   Marital: MARRIED
[4] Veteran: YES                Eligibility: NON SERVICE CONNECTED

[5] Address: 123 TREE WAY         Temporary: NO TEMPORARY ADDRESS
             RYE, NY  12222
[6] Patient Short Address: 123 TREE WAY,RYE,NY 12222

[7] SC Care: NO


<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:  ^3


STRAIT,SAM   321-123-321    BILL#: 90014A - Outpatient              SCREEN <3>
==============================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.           Form Type: UB-92
    Payer      : INSURER

    Insurance Co.   Subscriber ID   Group        Holder   Effective  Expires
==============================================================================
    AETNA           345678          UNSPECIFIED  SPOUSE   09/15/91   09/15/92
    PRUDENTIAL      09718940        3009         VETERAN  01/01/92   12/31/92

[2] Primary Provider #  :
    Secondary Provider #:                    Tertiary Provider #:

[3] Mailing Address :
    AETNA
    124 FOX ROAD
    DALLAS, TX  65776

<RET> to CONTINUE, 1-3 to EDIT, ^N for screen N, or '^' to QUIT:  3
```

EXAMPLE, cont.

```
MAILING ADDRESS NAME: AETNA//  <RET>
MAILING ADDRESS STREET: 124 FOX ROAD//  67 NEWTIN DRIVE
MAILING ADDRESS STREET2:  <RET>
MAILING ADDRESS CITY: DALLAS//  HOUSTON
MAILING ADDRESS STATE: TEXAS//  <RET>
MAILING ADDRESS ZIP CODE: 65776//  68788
```

```
STRAIT,SAM   321-123-321    BILL#: 90014A - Outpatient              SCREEN <3>
================================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.           Form Type: UB-92
    Payer      : INSURER

    Insurance Co.   Subscriber ID   Group        Holder   Effective  Expires
================================================================================
    AETNA           345678          UNSPECIFIED  SPOUSE   09/15/91   09/15/92
    PRUDENTIAL      09718940        3009         VETERAN  01/01/92   12/31/92

[2] Primary Provider #  :
    Secondary Provider #:                    Tertiary Provider #:

[3] Mailing Address :
    AETNA
    67 NEWTIN DRIVE
    HOUSTON, TX  68788


<RET> to CONTINUE, 1-3 to EDIT, ^N for screen N, or '^' to QUIT:  ^8
```

EXAMPLE, cont.

```
STRAIT,SAM   321-123-321    BILL#: 90014A - Outpatient              SCREEN <8>
================================================================================
                    BILLING - SPECIFIC INFORMATION
[1] Bill Remark     : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code   : UNSPECIFIED [NOT REQUIRED]
    Admitting Dx    : UNSPECIFIED [NOT REQUIRED]
[2] Attending Phy.  : UNSPECIFIED [NOT REQUIRED]
    Other Physician : UNSPECIFIED [NOT REQUIRED]
[3] Form Locator 2  : UNSPECIFIED [NOT REQUIRED]
    Form Locator 11 : UNSPECIFIED [NOT REQUIRED]
[4] Form Locator 31 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 37 : UNSPECIFIED [NOT REQUIRED]
[5] Form Locator 56 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 57 : UNSPECIFIED [NOT REQUIRED]
    Form Locator 78 : UNSPECIFIED [NOT REQUIRED]


<RET> to QUIT, 1-5 to EDIT, ^N for screen N, or '^' to QUIT:  <RET>

No Errors found

Entered        : FEB 13,1990 by ROYBORN,PAUL
Authorized     : FEB 14,1990 by SAWYER,MARY
Last Printed   : FEB 14,1990 by SAWYER,MARY

WANT TO EDIT SCREENS? NO//  <RET>   (NO)

WANT TO RETURN BILL TO AR AT THIS TIME? NO//  Y   (YES)
RETURNED COMMENTS:  <RET>
RETURN TO A/R?  Y   (YES)
Passing completed Bill to Accounts Receivable.  Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.

Entered        : FEB 13,1990 by ROYBORN,PAUL
Authorized     : FEB 14,1990 by SAWYER,MARY
Last Printed   : FEB 14,1990 by SAWYER,MARY
Returned to AR : FEB 17,1990 by CURTIN,JESSIE

WANT TO RE-PRINT BILL AT THIS TIME? NO//  <RET>   (NO)
```

Third Party Billing Menu
Return Bill Menu
Returned Bill List

INTRODUCTION

The Returned Bill List option prints a listing of all bills that have been returned to MAS from Accounts Receivable. When you log on the Billing System, you may see the following message.

```
"You have {#} bill(s) returned from Fiscal (New Bill)."
```

When this occurs, you need to generate the output produced by this option to obtain a listing of the returned bills.

The following data items may be provided for each bill on the list: bill number, payer, previous and current status of bill, original bill amount, service which approved bill and when, returned by, reason returned, and date returned. The bill number appears on this report preceded by the station number. The station number should not be entered when selecting the bill for editing.

You will need this report when using the Edit Returned Bill option to determine why the bill was returned and what needs to be corrected. Once the bills have been corrected and sent back to Accounts Receivable, they no longer will appear on the Returned Bill List.

Due to the brevity of this option, a process chart has not been provided.

Third Party Billing Menu
Return Bill Menu
Returned Bill List

EXAMPLE
The following is an example of what might appear on your screen while using the Returned Bill List option. User responses are shown in boldface type. An example of the output generated by this option is provided below.

```
Select Returned Bill Menu Option:  RETURNED Bill List
DEVICE:  A137      RIGHT MARGIN: 80//  <RET>
DO YOU WANT YOUR OUTPUT QUEUED? NO//  Y   (YES)

REQUESTED TIME TO PRINT: NOW//  <RET>
REQUEST QUEUED!
```

```
                          << BILL RETURNED FROM AR >>
================================================================================
BILL NO.:  500-90032A                    PAYER: AETNA
PREV. STATUS: NEW BILL                   CURR. STATUS:  RETURNED FROM AR (NEW)
ORIGINAL AMOUNT: $70                     SERVICE: MEDICAL ADMINISTRATION

                                    << SERVICE >>
APPROV. BY: DOUGLAS,JAMES                DATE: JUL 2,1990

                                    << FISCAL >>
RETN'D BY:  SPINNER,ALAN                 DATE:  JUL  5,1990
RETN'D REASON:
   RETURNED FOR CORRECT RATES
================================================================================
                          << BILL RETURNED FROM AR >>
================================================================================
BILL NO.: 500-K00006                     PAYER: AETNA
PREV. STATUS: NEW BILL                   CURR. STATUS:  RETURNED FROM AR (NEW)
ORIGINAL AMOUNT: $673                    SERVICE: MEDICAL ADMINISTRATION

                                    << SERVICE >>
APPROV. BY: DOUGLAS,JAMES                DATE: JUL 2,1990

                                    << FISCAL >>
RETN'D BY:  SPINNER,ALAN                 DATE:  JUL  5,1990
RETN'D REASON:
   RETURNED FOR CORRECT INS ADDRESS
```

Third Party Billing Menu
Return Bill Menu
Return Bill to A/R

INTRODUCTION

The Return Bill to A/R option is used to send bills which have been returned to MAS back to Accounts Receivable after they have been corrected. Editing is not allowed in this option. All editing is done through the Edit Returned Bill option; however, all billing screens associated with the bill may be displayed for viewing.

The IB AUTHORIZE security key is required to access this option.

The chart beginning on the following page shows the prompts and steps involved in using this option.

Third Party Billing Menu
Return Bill Menu
Return Bill to A/R

PROCESS
The following chart shows the prompts and steps involved in using the Return Bill to A/R option.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	Only bills returned from Accounts Receivable may be selected. If the patient name or event date is entered, all applicable bills for that patient or with that event date will be listed for selection.		
1	Select BILL/CLAIMS BILL NUMBER:	.patient name	2
		.event date	2
		.bill number	2
		.<RET> or up-arrow <^>	10
2	No Errors found		
	Entered	: {DATE} by {NAME}	
	First Reviewed	: {DATE} by {NAME}	
	Last Reviewed	: {DATE} by {NAME}	
	Authorized	: {DATE} by {NAME}	
	Last Printed	: {DATE} by {NAME}	
	WANT TO REVIEW SCREENS? NO//	.<RET> or NO	4
		.YES	3
3	The screens listed below may now be displayed individually for review. Editing is not allowed through this option. If editing is necessary, please see the Enter/Edit Billing Information option contained in this section of the manual. After review, you will proceed to Step 4.		

I=inpatient bill screen O=outpatient bill screen B=both

Screen 1	Demographic Information	B
Screen 2	Employment Information	B
Screen 3	Payer Information	B
Screen 4	Event-Inpatient Information	I
Screen 5	Event-Outpatient Information	0
Screen 6	Billing-General Information	I
Screen 7	Billing-General Information	0
Screen 8	Billing-Specific Information	B

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
4	WANT TO RETURN BILL TO AR AT THIS TIME? NO//	.<RET> or NO	1
		.YES	5
5	RETURN COMMENTS:	.comments (3-80 chars.)	6
		.<RET> to leave blank	6
6	RETURN TO A/R?	.YES	7
		.NO	1
7	Passing completed Bill to Accounts Receivable. Bill is no longer editable. Completed Bill Successfully sent to Accounts Receivable. Entered : {DATE} by {NAME} First Reviewed : {DATE} by {NAME} Last Reviewed : {DATE} by {NAME} Authorized : {DATE} by {NAME} Last Printed : {DATE} by {NAME} Returned to AR : {DATE} by {NAME} WANT TO {PRINT/REPRINT} BILL AT THIS TIME? NO//	.<RET> or NO	1
		.YES	8

PROCESS, cont.

STEP	AT THIS PROMPT...	IF USER ANSWERS WITH...	THEN STEP
	You may choose to reprint the bill with the heading "SECOND NOTICE - 30 DAYS OVERDUE" or "THIRD NOTICE - 60 DAYS OVERDUE". "*** COPY OF ORIGINAL BILL ***" will appear at the top of the reprinted bill if (C)OPY is entered. Selecting ORIGINAL at this prompt will allow reprinting of the bill without that heading. This should only be used when the original bill did not print correctly and has been destroyed.		
8	(2)nd Notice, (3)rd Notice, (C)opy or (O)riginal: C//	.2 for second notice bill .3 for third notice bill .C for copy of bill .O for original bill	9 9 9 9
9	You will be prompted for a device at this Step.		1
10	Return to the menu.		

Third Party Billing Menu
Return Bill Menu
Return Bill to A/R

EXAMPLE
The following is an example of what might appear on the screen while using the Return Bill to A/R option. User responses are shown in boldface type.

```
Select BILL/CLAIMS BILL NUMBER:  90014A   STRAIT,SAM   01-18-90   MEANS
TEST/CAT C   PRINTED

No Errors found

Entered        : FEB 13,1990 by ROYBORN,PAUL
First Reviewed : FEB 13,1990 by ROYBORN,PAUL
Last Reviewed  : FEB 13,1990 by ROYBORN,PAUL
Authorized     : FEB 14,1990 by SAWYER,MARY
Last Printed   : FEB 14,1990 by SAWYER,MARY

WANT TO REVIEW SCREENS? NO//  <RET>   (NO)

WANT TO RETURN BILL TO AR AT THIS TIME? NO//  Y   (YES)
RETURNED COMMENTS:  <RET>
RETURN TO A/R?  Y   (YES)
Passing completed Bill to Accounts Receivable.  Bill is no longer
editable.  Completed Bill Successfully sent to Accounts Receivable.

Entered        : FEB 13,1990 by ROYBORN,PAUL
First Reviewed : FEB 13,1990 by ROYBORN,PAUL
Last Reviewed  : FEB 13,1990 by ROYBORN,PAUL
Authorized     : FEB 14,1990 by SAWYER,MARY
Last Printed   : FEB 14,1990 by SAWYER,MARY
Returned to AR : FEB 17,1990 by CURTIN,JESSIE

WANT TO RE-PRINT BILL AT THIS TIME? NO//  <RET>   (NO)

Select BILL/CLAIMS BILL NUMBER:
```

Third Party Billing Menu
UB-82 Test Pattern Print

INTRODUCTION

The UB-82 Test Pattern Print option is used to print a test pattern on the UB-82 billing form so that the form alignment in the printer may be checked. This will insure that each data item prints in the correct block on the form.

The test pattern displays what data element should appear in the different blocks of the billing form. For example, in Block 3 - Patient Control Number, "BILL NUMBER" will be printed in that block when this option is utilized.

Due to the brevity of this option, no process chart is provided.

Third Party Billing Menu
UB-82 Test Pattern Print

EXAMPLE

The following is an example of what might appear on your screen while utilizing this option followed by the output. User responses appear in boldface type.

```
Select Third Party Billing Menu Option: TEST  UB-82 Test Pattern Print
DEVICE: HOME// <RET>   LAT    RIGHT MARGIN: 80// 132


                *** UB-82 TEST PATTERN ***
AGENT CASHIER
AGENT CASHIER STREET     F. L. 2                        BILL NUMBER      XXX
CITY STATE  ZIP
PHONE #                BC/BS #       FED TAX #                       F. L. 9

PATIENT NAME                     PATIENT ADDRESS

PT DOB  X X   ADM DT HR  X  X AH DH XX  FROM    TO                  F. L. 27

OC DATE    OC DATE    OC DATE      OC DATE    OC DATE
MAILING ADDRESS NAME
STREET ADDRESS 1              CC CC CC CC CC                F. L. 45
STREET ADDRESS 2
STREET ADDRESS 3
CITY  STATE  ZIP


000 DAYS MEDICAL CARE

REV CODE 1              000.00 000 00    0000.00
REV CODE 2              000.00 000 00    0000.00
REV CODE 3              000.00 000 00    0000.00

SUBTOTAL                                 00000.00



TOTAL                                    00000.00



PAYER 1                 X  X
PAYER 2                 X  X
PAYER 3                 X  X


INSURED NAME 1         X  XX POLICY # 1       GROUP NAME 1   GROUP # 1
INSURED NAME 2         X  XX POLICY # 2       GROUP NAME 2   GROUP # 2
INSURED NAME 3         X  XX POLICY # 3       GROUP NAME 3   GROUP # 3

X X EMPLOYER NAME                        CITY  STATE  ZIP


PRINCIPAL DIAGNOSIS                        CODE   CODE   CODE   CODE   CODE

X  PRINCIPAL PROCEDURE                     CODE   DATE  CODE  DATE CODE  DATE

                     TX. AUTH.  Dept. Veterans Affairs F. L. 93

Patient ID: XXXXXXXXX
Bill Type: XXXX XXXXXXX
UB-82 TEST PATTERN
**TEST PATTERN**                           UB-82 SIGNER NAME
                                           UB-82 SIGNER TITLE     DATE
```

Third Party Billing Menu
UB-92 Test Pattern Print

INTRODUCTION The UB-92 Test Pattern Print option is used to print a test pattern on the UB-92 billing form so that the form alignment in the printer may be checked. This will insure that each data item prints in the correct block on the form.

Due to the brevity of this option, no process chart is provided.

Third Party Billing Menu
UB-92 Test Pattern Print

EXAMPLE

The following is an example of what might appear on your screen while utilizing this option followed by the output. User responses appear in boldface type.

```
Select Third Party Billing Menu Option: TP92  UB-92 Test Pattern Print
DEVICE: HOME// <RET>   LAT    RIGHT MARGIN: 80// 132


##SR                              *** UB-92 TEST PATTERN ***
AGENT CASHIER
AGENT CASHIER STREET                                      BN XXX             XXX
CITY  STATE  ZIP
PHONE #                  TAX# XXXX  5/1/93 5/4/93

PATIENT NAME                   PT SHORT ADDRESS

DOB      X  X DATE   HR  X  X DR ST 000-00-0000       CC CC CC CC CC CC CC

OC DATE   OC DATE   OC DATE   OC DATE   OC DATE

RESPONSIBLE PARTY'S NAME
STREET ADDRESS 1
STREET ADDRESS 2
STREET ADDRESS 3
CITY  STATE  ZIP

CD1  REV CODE description                      xx       xxxx.xx
CD2  REV CODE description                      xx       xxxx.xx
CD3  REV CODE description                      xx       xxxx.xx
     Subtotal                                           xxxx.xx

     Total                                              xxxx.xx


For your information, even though the patient may be otherwise eligible
for Medicare, no payment may be made under Medicare to any Federal provider
of medical care or services and may not be used as a reason for non-payment.
Please make your check payable to the Department of Veterans Affairs and
send to the address listed above.

The undersigned certifies that treatment rendered is not for a
service connected disability.

Name of Payer 1          Provider #    x  x
Name of Payer 2          Provider #    x  x
Name of Payer 3          Provider #    x  x


Insured's Name 1         x  Insurance #         Group Name     Group #
Insured's Name 2         x  Insurance #         Group Name     Group #
Insured's Name 3         x  Insurance #         Group Name     Group #

Treatment Auth. Cd x Employer Name            Employer Location
                   x Employer Name            Employer Location
                   x Employer Name            Employer Location

PDX    Dx Cd  Dx Cd  Dx Cd  Dx Cd  Dx Cd  Dx Cd  Dx Cd  Dx Cd   ADMT DX

   P-code  mmddyy P-code  mmddyy P-code  mmddyy     Attending Phys. ID#

   P-code  mmddyy P-code  mmddyy P-code  mmddyy     Other Phys. ID#
       Patient ID#: xxx-xx-xxxx
Bill Type: xxx xxxxxx
UB 92 TEST PATTERN                                  Provider Representative DATE
*** comment ***
```

Third Party Billing Menu
HCFA-1500 Test Pattern Print

INTRODUCTION This option allows you to print a test pattern on the HCFA-1500 form in order for the form alignment in the printer to be checked. The test pattern displays what data element should appear in the different blocks of the billing form. This insures that each data item prints in the correct block on the form.

Due to the brevity of this option, no process chart is provided.

Third Party Billing Menu
HCFA-1500 Test Pattern Print

EXAMPLE

The following is an example of what might appear on your screen while utilizing this option followed by the output. User responses appear in boldface type.

```
Select Third Party Billing Menu Option: TSTH  HCFA-1500 Test Pattern Print
DEVICE: HOME// <RET>   LAT    RIGHT MARGIN: 80// 132


INSURANCE CARRIER NAME
CARRIER ADDRESS LINE 1
CARRIER ADDRESS LINE 2
CARRIER ADDRESS LINE 3
CARRIER CITY, STATE ZIP

                                          SUBSCRIBER ID#

PATIENT NAME                 MM DD YY     INSURED'S NAME

PATIENT ADDRESS STREET                    INSURED'S ADDRESS STREET

PATIENT ADDRESS CITY     ST               INSURED'S ADDRESS CITY  ST

PT ZIP CODE   999 999-9999                INS ZIP CODE   999 999-9999

OTHER INSURED'S NAME                      INSURED'S POLICY GROUP

OTHER POLICY NUMBER                           MM DD YY

 MM DD YY                              ST   INSURED'S EMPLOYER

OTHER'S EMPLOYER                          INSURANCE PLAN NAME

OTHER'S INSURANCE PLAN

 MM DD YY                      MM DD YY     MM DD YY      MM DD YY

REFERRING PHYSICIAN        PHYSICIAN ID     MM DD YY      MM DD YY

                                                    9999.99  9999.99

  X99.99                    X99.99

  X99.99                    X99.99

MM DD YY MM DD YY        CPT    MODIF    DIAG     9999.99            BC/BS#

MM DD YY MM DD YY        CPT    MODIF    DIAG     9999.99            BC/BS#

MM DD YY MM DD YY        CPT    MODIF    DIAG     9999.99            BC/BS#

MM DD YY MM DD YY        CPT    MODIF    DIAG     9999.99            BC/BS#

MM DD YY MM DD YY        CPT    MODIF    DIAG     9999.99            BC/BS#

MM DD YY MM DD YY        CPT    MODIF    DIAG     9999.99            BC/BS#

FEDERAL TAX ID        PAT ACCT#                  9999.99   9999.99  9999.99

                      VAMC                   AGENT CASHIER  (999) 999-9999
                      STREET ADDRESS         STREET ADDRESS
                      CITY, STATE ZIP        CITY, STATE ZIP
```

Third Party Billing Menu
Outpatient Visit Date Inquiry

INTRODUCTION

The Outpatient Visit Date Inquiry option allows you to display information on any outpatient insurance bill for a selected patient. You will be prompted for a patient name and an outpatient visit date. You may select any patient with billed outpatient visits. <??> may be entered at the second prompt for a list of billed visits for the selected patient.

The information provided includes bill status, rate type, reason cancelled (if applicable), outpatient visit date, charges, amount paid, statement from and to dates, each action that was taken on that bill, the date, and the user who performed it.

Due to the brevity of this option, no process chart is provided.

Third Party Billing Menu
Outpatient Visit Date Inquiry

EXAMPLE
The following is an example of what might appear on the screen while using the Outpatient Visit Date Inquiry option. User responses are shown in boldface type.

```
Select PATIENT NAME:  ALLEN,JOHN A      01-01-44     442121211    NSC VETERAN

Select OP Visit Date:  ??

     Enter one of the following OP visit dates:

     01-25-92       L10171    REIMBURSABLE INS.        CANCELLED
     02-13-92       L10386    REIMBURSABLE INS         PRINTED

Select OP Visit Date:  1/25/92  (JAN 25, 1992)
```

```
ALLEN,JOHN A    442-12-1211       500-L10171    MAR 19, 1992@14:17     PAGE: 1
================================================================================
Bill Status    : CANCELLED - RECORD IS UNEDITABLE
Rate Type      : REIMBURSABLE INS.
Reason Canceled: WRITE OFF

Op Visit dates : JAN 25,1992

Charges        :  $148.00
LESS Offset    :   $30.00
Bill Total     :  $118.00

Statement From : JAN 25,1991
Statement To   : JAN 25,1991

Entered        : FEB 15, 1991 by CORCHRAN,EDWARD
First Reviewed : FEB 16, 1991 by MIX,SUE
Last Reviewed  : FEB 16, 1991 by MIX,SUE
Authorized     : FEB 16, 1991 by MIX,SUE
Last Printed   : FEB 16, 1991 by HOOPER,GARY
Cancelled      : MAR  6, 1992 by LYNCH,KATHERINE



Press RETURN to continue or '^' to exit:
```

Third Party Joint Inquiry

INTRODUCTION

This option provides information needed to answer questions from insurance carriers regarding specific bills or episodes of care. This information is presented in List Manager Screens.

Because the same actions are available on most screens, and most screens can be accessed from any other screen; these "Common Actions" are listed first and are not repeated under each screen description. Only actions specific to a screen are included with that screen description.

You may QUIT from any screen which will bring you back one level or screen. EXIT is also available on most screens. EXIT returns you to the menu. For more information on the use of the List Manager utility, please refer to the appendix at the end of this manual.

Actions shown in italics access other screens.

Common Actions

BC Bill Charges - Accesses the Bill Charges screen.

DX Bill Diagnoses - Accesses the Bill Diagnoses screen.

PR Bill Procedures - Accesses the Bill Procedures screen.

CI Go to Claim Screen - Returns you to the Claim Information screen. Available on all screens that may be opened from the Claim Information screen.

AR Account Profile - Accesses the AR Account Profile screen.

CM Comment History - Accesses the AR Comment History screen.

IR Insurance Reviews - Accesses the Insurance Reviews/ Contacts screen.

INTRODUCTION cont.

HS Health Summary - Displays a Health Summary report. The information displayed on the Health Summary is site specified through the MCCR Site Parameter Display/Edit option.

AL Go to Active List - Returns you to the Third Party Active Bills screen if that screen was accessed upon entering this option; otherwise, this action returns you to the menu.

VI Insurance Company - Accesses the Insurance Company screen.

VP Policy - Accesses the Patient Policy Information screen.

AB Annual Benefits - Accesses the Annual Benefits screen.

EL Patient Eligibility - Accesses the Patient Eligibility screen.

EX Exit Action - Exits the option.

Third Party Active Bills Screen

This is the first screen displayed if you enter a patient name at the first prompt of this option. It lists all active third party bills for the specified patient in order of date created. All bills created in the Integrated Billing Third Party Billing module can be found on this screen or the Inactive Bills screen.

Actions

IL Inactive Bills - Accesses the Inactive Bills screen.

PI Patient Insurance - Accesses the Patient Insurance screen.

CP Change Patient - Allows you to choose another patient and re-displays the Third Party Active Bills screen for that patient.

INTRODUCTION cont.

Inactive Bills Screen

This screen lists inactive bills for a specified patient. All bills created in the Integrated Billing Third Party Billing module are found on this screen or the Third Party Active Bills screen. Bills are displayed beginning with most recent "statement from" date.

Actions

CD Change Dates - Allows you to change the bills listed by changing the most recent "statement from" date to be displayed.

Patient Insurance Screen

This screen displays the list of insurance policies for a patient. It is based on the Patient Insurance Management screen of the Patient Insurance Info View/Edit option. It is only available from the Third Party Active Bills screen.

Claim Information Screen

This screen contains bill data and status information to provide an overall status of the bill. This is the primary claim screen for the inquiry, and many actions are provided to expand on the details of the claim.

If a policy has been updated but the bill has not, those changes are not reflected on this screen. Updated or current insurance information may be viewed using the three insurance screens.

Actions

CB Change Bill - Allows you to change the bill being displayed. If you entered a patient name at the first prompt of this option, only bills for that patient may be selected. If you entered a bill number at the first prompt, any bill may be selected.

INTRODUCTION cont.

Bill Charges Screen
This screen displays a bill's charge information as it would print on the bill. For UB-92 bills, this closely corresponds to Form Locators 42-49; therefore, any prosthetic items, Rx refills, or additional diagnoses and procedures are included. For HCFA 1500 bills, this closely corresponds to Block 24.

Bill Diagnosis Screen
This screen displays all diagnoses assigned to the bill, in the order they are printed on the bill.

Bill Procedures Screen
This screen lists all procedures assigned to a bill, in the order they are printed on the bill.

AR Account Profile Screen
This screen provides the financial history of a claim's account. This includes the current status of the bill in both IB and AR, as well as the payment or transaction history of the bill from Accounts Receivable. This screen is loosely based on the Profile of Accounts Receivable option.

Actions

VT Transaction Profile - Accesses the AR Transaction Profile screen for a selected transaction.

AR Transaction Profile Screen
This screen displays detailed account transaction information for individual claim transactions. It is is loosely based on the Accounts Receivable Transaction Profile option.

INTRODUCTION cont.

AR Comment History Screen

This screen displays AR comments for the claim's account.

Actions

AD Add AR Comment - Allows you to add an AR Transaction Comment to the bill being displayed. Comment transactions may not be added to a bill that has not been authorized in IB.

Insurance Reviews/Contacts Screen

This screen displays all insurance reviews and contacts for the episodes of care on a bill. It is based on the Insurance Reviews/Contacts screen of the Claims Tracking Insurance Review Edit option. The primary difference between the two screens is that this screen consolidates all contacts for each episode being billed on a claim, while the Claims Tracking screen displays the contacts for a single episode of care.

Actions

VR Reviews/Appeals - Displays expanded information on a selected insurance contact. The screen accessed by this action will depend on the type of contact selected. If the contact is an appeal or denial, the Expanded Appeals/Denials screen is opened; otherwise, the Expanded Insurance Reviews screen is opened.

Expanded Appeals/Denials Screen

This screen displays expanded information on insurance appeals and denials listed on the Insurance Review/Contacts screen. This screen is based on the Expanded Appeals/Denials screen of the Claims Tracking Appeal/Denial Edit option.

Expanded Insurance Reviews Screen

This screen displays expanded information on insurance reviews listed on the Insurance Reviews/Contacts screen. This screen is based on the Expanded Insurance Reviews screen of the Claims Tracking Insurance Review Edit option.

INTRODUCTION cont.

Insurance Company Screen

This screen displays extended information on an Insurance Company. It is based on the Insurance Company Editor screen of the Insurance Company Entry/Edit option. This screen may be entered from the Patient Insurance screen or from any of the bill specific screens. Once a bill is selected, this screen displays only information related to the insurance carriers assigned to that bill.

Patient Policy Information Screen

This screen displays extended information on insurance policies. It is based on the Patient Policy Information screen of the Patient Insurance Info View/Edit option. This screen may be entered from either the Patient Insurance screen or from any of the bill specific screens. Once a bill is selected, this screen will only display information related to the insurance policies assigned to the bill.

Annual Benefits Screen

This screen displays extended information on the annual benefits of insurance policies. It is based on the Annual Benefits Editor screen of the Patient Insurance Info View/Edit option. This screen may be entered from the Patient Insurance screen or from any of the bill specific screens. Once a bill has been chosen, this screen displays information related to the insurance policies assigned to that bill.

INTRODUCTION cont.

Patient Eligibility Screen

This screen displays the current information on the patient's eligibility for care and service connection status. It is loosely based on the Eligibility Inquiry for Patient Billing option. This screen is available from the Third Party Active Bills screen and the bill specific screens.

If this screen is accessed from one of the bill specific screens, such as the Claim Information screen, the standard list of bill screen actions will be available from this screen.

If this screen is accessed from the Patient Insurance screen, no other screens are available as actions from this screen; and you must return to a previous screen to access other screens.

Due to the nature of this option, no process chart is provided.

Third Party Joint Inquiry

EXAMPLE

The following examples show the various screens available through this option.

Third Party Active Bills May 31, 1995 @10:07:11 Page 1 of 1

JONES,ANDREW A9281 NSC

Bill #		From	To	Type	Stat	Rate	Insurer	Orig Amt	Curr Amt
1 L10263		04/20/92	04/20/92	OP	BI	REIM INS	HEALTH	0.00	0.00
2 L10270		04/20/92	04/24/92	OP	PC	REIM INS	HEALTH	698.30	698.30
3 N10072	*	11/16/93	11/17/93	OP	N	REIM INS	+ HEALTH	199.00	199.00
4 N10094		02/16/94	02/16/94	OP	PC	REIM INS	+ HEALTH	196.00	196.00
5 N10123	*	03/01/94	03/15/94	OP	BI	REIM INS	+ HEALTH	0.00	0.00
6 N10150	*	03/14/94	03/15/94	OP	BI	REIM INS	+ AETNA	0.00	0.00
7 N10173	*	03/02/94	03/03/94	OP	BI	REIM INS	AETNA	0.00	0.00
8 N10174	*	03/06/94	03/07/94	OP	N	REIM INS	AETNA	356.00	356.00
9 N10222		05/01/94	05/31/94	IP-F	BI	REIM INS	HEALTH	0.00	0.00
10 N10236		06/01/94	06/05/94	IP-L	BI	REIM INS	HEALTH	0.00	0.00
11 N10273	*	03/03/94	03/31/94	IP-F	A	REIM INS	+ HEALTH	11221.00	856.45
12 N10275		08/30/94	09/30/94	IP	BI	REIM INS	AETNA	0.00	0.00

\+ | * Cat C Charges on Hold | + 2nd/3rd Carrier |

CI Claim Information IL Inactive Bills PI Patient Insurance
CP Change Patient HS Health Summary EL Patient Eligibility
Select Action: Next Screen//

Inactive Bills May 17, 1996 13:30:26 Page: 1 of 2

JONES,ANDREW A9281 ** All Inactive Bills ** (9)

Bill #		From	To	Type	Stat	Rate	Insurer	Orig Amt	Curr Amt
1 N10397		06/01/94	06/05/94	IL-L	CC	REIM INS	+ AETNA	935.00	0.00
2 N10198		06/01/94	06/05/94	IP-L	CB	REIM INS	+ HEALTH	0.00	0.00
3 N10212		05/07/94	05/12/94	IP-C	CB	REIM INS	HEALTH	0.00	0.00
4 N10148	*	03/02/94	03/03/94	OP	CB	REIM INS		0.00	0.00
5 N10162	*	03/02/94	03/03/94	OP	CB	REIM INS		0.00	0.00
6 N10095		02/16/94	02/16/94	OP	CB	REIM INS		0.00	0.00
7 L10260		04/14/92	04/20/92	OP-F	CB	REIM INS	AETNA	1026.02	1026.02
8 L00389		02/08/90	02/08/90	OP	CC	REIM INS	BC/BS	26.00	0.00
9 00036A		02/07/90	02/07/90	OP	CC	REIM INS	BC/BS	26.00	0.00

\+ |* Cat C Charges on Hold |+ 2nd/3rd Carrier |

CI Claim Information AL Go to Active List CD Change Dates
EX Exit Action
Select Action: Next Screen//

Third Party Joint Inquiry

EXAMPLE, cont.

Claim Information May 17, 1996 13:44:58 Page: 1 of 2
N10072 JONES,ANDREW A9281 DOB: 5/22/50 Subsc ID: 9849333

Insurance Demographics		**Subscriber Demographics**	
Carrier Name:	HEALTH INS LIMITED	Group Number:	GN 48923222
Claim Address:	789 3RD STREET	Group Name:	
	ALBANY, NY 44438	Subscriber ID:	9849333
Claim Phone:	333-444-5676	Employer:	Snow Movers
		Insured's Name:	JONES,ANDREW
		Relationship:	PATIENT

Claim Information

Bill Type:	OUTPATIENT	Service Dates:	11/16/93 - 11/17/93
Time Frame:	ADMIT THRU DISCHARGE CLAIM	Date Entered:	12/23/93
Rate Type:	REIMBURSABLE INS	Orig Claim:	199.00
AR Status:	NEW BILL	Balance Due:	199.00
Secondary:	AETNA		

Entered:	12/23/93	by	Gray,John
Authorized:	01/04/94	by	Smith,Jane
First Printed:	01/04/94	by	Smith,Jane
Last Printed:	04/01/94	by	Brown,Deb

\+ Enter ?? for more actions

BC	Bill Charges	AR	Account Profile	VI	Insurance Company
DX	Bill Diagnosis	CM	Comment History	VP	Policy
PR	Bill Procedures	IR	Insurance Reviews	AB	Annual Benefits
CB	Change Bill	HS	Health Summary	EL	Patient Eligibility
		AL	Go to Active List	EX	Exit Action

Select Action: Next Screen//

Patient Insurance May 31, 1995 @10:07:11 Page 1 of 1
Insurance Management for Patient: JONES,ANDREW A9281

	Insurance Co.	Type of Policy	Group	Holder	Effect.	Expires
1	HEALTH INS LTD		GN 48923222	SELF	01/01/87	
2	AETNA	MAJOR MEDICAL	AE 76899354	SPOUSE	10/1/90	19/30/95
3	PRUDENTIAL	INDEMNITY	T109	OTHER	10/1/94	01/01/95
4	BC/BS	MAJOR MEDICAL	GN 392043	SELF	01/01/90	12/31/92

VI	Insurance Company	VP	Policy	AB	Annual Benefits
AL	Go to Active List			EX	Exit Action

Select Action: Quit//

Third Party Joint Inquiry

EXAMPLE, cont.

```
Bill Charges                    May 31, 1995 @10:07:11              Page 1 of 1
N10072  JONES,ANDREW     A9281  DOB: 5/22/50              Subsc ID: 9849333
11/16/93 - 11/17/93        ADMIT THRU DISCHARGE          Orig Amt:    199.00
-------------------------------------------------------------------------------

      OUTPATIENT VISIT
500   OUTPATIENT SVS         178.00         1                178.00
      PRESCRIPTION
257   DRGS/NONSCRPT           21.00         1                 21.00

001   TOTAL CHARGE                                           199.00

      OP VISIT DATE(S) BILLED:         NOV 16, 1993

      PRESCRIPTION REFILLS:
      30948          NOV 17, 1993      ABBOCATH-T 18G 1.25 IN
                                       QTY: 20 for 10 days supply

Bill Remark:  This is a demonstration bill created for Joint Billing Inquiry.

-------------------------------------------------------------------------------
          Enter ?? for more actions
-------------------------------------------------------------------------------
DX  Bill Diagnosis        AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

EXAMPLE, cont.

```
Bill Charges                    May 31, 1995 @10:07:11            Page 1 of 1
N10273  JONES,ANDREW     A9281  DOB: 5/22/50              Subsc ID:  9849333
03/02/94 - 03/31/94        INTERIM - FIRST CLAIM         Orig Amt: 11221.00
-------------------------------------------------------------------------------

30 DAYS INPATIENT CARE
      INTERMEDIATE CARE
101   ALL INCL R&B           246.00         30           7380.00
240   ALL INCL ANCIL          48.00         30           1440.00
960   PRO FEE                 49.00         30           1470.00
274   PROSTH/ORTH DEV        931.00         1             931.00

001   TOTAL CHARGE                                      11221.00

      PROSTHETIC ITEMS:
      Sep 18, 1994  WHEELCHAIR
      Sep 21, 1994  CANE-ALL OTHER

-------------------------------------------------------------------------------
          Enter ?? for more actions
-------------------------------------------------------------------------------
DX  Bill Diagnosis        AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

EXAMPLE, cont.

```
Bill Diagnosis                 May 17, 1996 14:07:56         Page:    1 of    1
N10072   JONES,ANDREW  A9281           DOB: 5/22/50      Subsc ID: 9849333
 11/16/93 - 11/17/93        ADMIT THRU DISCHARGE CLAIM   Orig Amt:    199.00
-------------------------------------------------------------------------------

      1)  490.     BRONCHITIS NOS
      2)  030.1    TUBERCULOID LEPROSY
      3)  101.     VINCENT'S ANGINA
      4)  330.1    CEREBRAL LIPIDOSES
      5)  461.0    AC MAXILLARY SINUSITIS
      6)  310.0    FRONTAL LOBE SYNDROME
      7)  200.01   RETICULOSARCOMA HEAD

-------------------------------------------------------------------------------
          Enter ?? for more actions
-------------------------------------------------------------------------------
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
PR  Bill Procedures       CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Bill Procedures                May 17, 1996 14:12:58         Page:    1 of    1
N10072   JONES,ANDREW  A9281           DOB: 5/22/50      Subsc ID: 9849333
 11/16/93 - 11/17/93        ADMIT THRU DISCHARGE CLAIM   Orig Amt:    199.00
-------------------------------------------------------------------------------

 11000   SURGICAL CLEANSING OF SKIN      11/16/93
 11001   ADDITIONAL CLEANSING OF SKIN    11/16/93
 12001   REPAIR SUPERFICIAL WOUND(S)     11/16/93

-------------------------------------------------------------------------------
          Enter ?? for more actions
-------------------------------------------------------------------------------
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
CI  Go to Claim Screen    IR  Insurance Reviews     AB  Annual Benefits
                          HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
AR Account Profile              May 31, 1995 @10:07:11        Page:    1 of    1
N10273   JONES,ANDREW     A9281          DOB: 5/22/50   Subsc ID:  9849333
AR Status: ACTIVE         Orig Amt:    11221.00       Balance Due:  856.45

             04/01/94     IB Status:  Printed  (Last)     11221.00   11221.00
1   1578     05/07/94     PAYMENT (IN PART)                7856.21    3364.79
2   1598     07/07/94     PAYMENT (IN PART)                2508.34     856.45
3   1601     07/08/94     COMMENT                             0.00     856.45

    Total Collected:  10364.55
    Percent Collected:    92.37%
          Enter ?? for more actions
BC  Bill Charges          VT  Transaction Profile   VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
AR Transaction Profile          May 31, 1995 @10:07:11              Page 1 of 1
N10273  JONES,ANDREW     A9281  DOB: 5/22/50            Subsc ID:  9849333
AR Status:  ACTIVE              Orig Amt:    11221.00   Balance Due:  856.45

      TRANS. NO:  1578              TRANS. TYPE:  PAYMENT (IN PART)
    TRANS. DATE:  05/07/94          DATE POSTED:  05/10/94    (ARH)
  TRANS. AMOUNT:  7856.21             RECEIPT #:  D2982398

                                      BALANCE    COLLECTED
                                 ------------- ---------------
                  PRINCIPLE:          3364.79      7856.21
                  INTEREST:              0.00         0.00
                  ADMINISTRATIVE:        0.00         0.00
                  MARSHALL FEE:          0.00         0.00
                  COURT COST:            0.00         0.00
                                     --------    ---------
                  TOTAL:              3364.79      7856.21

       FY:  94            PR AMT: 3364.79           FY TR AMT: 7856.21

COMMENTS:   Date of Deposit: MAY 10, 1994

          Enter ?? for more actions
CI  Go to Claim Screen          AL Go to Active List        EX Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
AR Comment History            May 17, 1996 14:21:37         Page:    1 of    1
L10260   JONES,ANDREW     A9281        DOB: 5/22/50    Subsc ID:  AH33334
AR Status:  CANCELLED          Orig Amt: 1026.02       Balance Due: 1026.02

1582  04/21/92  Copy of bill sent.                FOLLOW-UP DT:  05/12/92
                Carrier did not receive initial bill.

1594  05/20/92  Bill canceled, wrong form type.    FOLLOW-UP DT:  06/01/92
                Carrier refuses to process this type of bill on a UB-92.
                They are requiring the HCFA 1500 form.

          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        AD  Add AR Comment        VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

```
Insurance Reviews/Contacts    May 31, 1995 @10:07:11        Page:    1 of    1
Insurance Review Entries for:  N10072     JONES,ANDREW     A9281
    Date       Ins. Co.           Type Contact       Action    Auth. No.  Days

    OUTPATIENT VISIT of AMBULATORY SURGERY OFFICE on 11/16/93
1   11/30/93   HEALTH INS LIMITED  1st Appeal-Clin    APPROVED  AU 39824
2   11/17/93   HEALTH INS LIMITED  OPT                DENIAL                0

    PRESCRIPTION REFILL of 30948 on 11/17/93
3   11/17/93   HEALTH INS LIMITED  OPT                APPROVED  RN 9384222

          Service Connected: NO   Previous Spec. Bills: TORT                >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       VR  Reviews/Appeals       AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

EXAMPLE, cont.

```
Expanded Appeals/Denials      May 31, 1995 @10:07:11            Page 1 of  2
Insurance Appeal/Denial for: JONES,ANDREW     A9281     ROI: NOT REQUIRED

          Visit Information                    Action Information
        Visit Type:  OUTPATIENT VISIT        Type Contact:  INITIAL APPEAL
        Visit Date:  03/09/94 9:00 am         Appeal Type:  CLINICAL
            Clinic:  AMBULATORY SURGERY       Case Status:  OPEN
      Appt. Status:  CHECKED OUT          No Days Pending:
        Appt. Type:  REGULAR                Final Outcome:
      Special Cond:

         Clinical Information              Appeal Address Information
          Provider:                         Ins. Co. Name:  HEALTH INS LIMITED
          Provider:                        Alternate Name:
         Diagnosis:                         Street line 1:  HIL - APPEALS OFFICE
         Diagnosis:                         Street line 2:  1099 THIRD AVE, SUITE
      Special Cond:                         Street line 3:
                                           City/State/Zip:  TROY, NY  12345

                      Insurance Policy Information
     Ins. Co. Name:  HEALTH INS LIMITED    Subscriber Name:  JONES,ANDREW
      Group Number:  GN 48923222             Subscriber ID:  9849333
  Whose Insurance:  VETERAN                 Effective Date:  01/01/87
   Pre-Cert Phone:  444-444-444 E          Expiration Date:

    User Information                      Contact Information
      Entered By:  SMITH,ALICE             Contact Date:  04/01/94
      Entered On:  11/16/93 3:30 pm   Person Contacted:  JANE,DOWNY
  Last Edited By:                       Contact Method:  PHONE
  Last Edited On:                     Call Ref. Number:  RN 3320944
                                           Review Date:  06/02/95
 Comments
 Policy should cover treatment.
 Service Connected Conditions:
 Service Connected: NO
 NO SC DISABILITIES LISTED
          Enter ?? for more actions                                      >>>
CI  Go to Claim Screen      AL Go to Active List    EX Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Expanded Insurance Reviews     May 31, 1995 @10:07:11          Page 1 of   2
Insurance Review Entries for:                          JONES,ANDREW     A9281
                    ROI: NOT REQUIRED

   Contact Information                    Action Information
     Contact Date:  11/17/93          Type Contact:  OUTPATIENT TREATMEN
 Person Contacted:  Steve            Opt Treatment:  RX REFILL
   Contact Method:  PHONE                    Action:  APPROVED
 Call Ref. Number:  RN 9384222       Auth. Number:  RN 9384222
      Review Date:  06/02/95

                        Insurance Policy Information
   Ins. Co. Name:  HEALTH INS LIMITED  Subscriber Name:  JONES,ANDREW
    Group Number:  GN 48923222           Subscriber ID:  9849333
 Whose Insurance:  VETERAN              Effective Date:  01/01/87
  Pre-Cert Phone:  933-3434            Expiration Date:

   Appeal Address Information           User Information
   Ins. Co. Name:  HEALTH INS LIMITED            Entered By: SMITH,ALICE
  Alternate Name:                                Entered On: 11/17/93 12:54 pm
   Street line 1:  HIL - APPEALS OFFICE       Last Edited By: SMITH,ALICE
   Street line 2:  1099 THIRD AVE, SUITE 301  Last Edited On: 11/20/93 12:55 pm
   Street line 3:
  City/State/Zip:  TROY, NY 12345

 Comments
 One refill of prescription approved.

 Service Connected Conditions:
 Service Connected: NO
 NO SC DISABILITIES LISTED
          Enter ?? for more actions                                        >>>
CI  Go to Claim Screen        AL Go to Active List          EX Exit Action
Select Action: Quit//
```

EXAMPLE, cont.
Insurance Company Screen

Insurance Company May 17, 1996 15:25:42 Page: 1 of 5
Insurance Company Information for: HEALTH INS LIMITED Primary
Type of Company: HEALTH INSURANCE Currently Active

Billing Parameters

Signature Required?:	YES	Attending Phys. ID:	AT PH ID VAH500000
Reimburse?:	WILL REIMBURSE	Hosp. Provider No.:	
Mult. Bedsections:	YES	Primary Form Type:	
Diff. Rev. Codes:		Billing Phone:	
One Opt. Visit:	NO	Verification Phone:	
Amb. Sur. Rev. Code:		Precert Comp. Name:	ABC INSURANCE
Rx Refill Rev. Code:		Precert Phone:	444-444-4444 E
Filing Time Frame:			

Main Mailing Address

Street:	2345 CENTRAL AVENUE	City/State:	ALBANY, NY 12345
Street 2:	FREAR BUILDING	Phone:	456-1234
Street 3:		Fax:	848-4884

Inpatient Claims Office Information

Street:	2345 CENTRAL AVENUE	City/State:	ALBANY, NY 12345
Street 2:	FREAR BUILDING	Phone:	456-0392
Street 3:		Fax:	848-4432

Outpatient Claims Office Information

Street:	789 3RD STREET	City/State:	ALBANY, NY 12345
Street 2:		Phone:	333-444-5676
Street 3:		Fax:	333-444-9245

EXAMPLE, cont.
Insurance Company Screen, cont.

```
                 Prescription Claims Office Information
   Company Name:  GHI PROCESSING              Street 3:
         Street:  1933 CORPORATE DRIVE      City/State:  RIVERSIDE, NY 39332
      Street 2:   TANGLEWOOD PARK                Phone:  339-0000
            Fax:

                      Appeals Office Information
         Street:  HIL - APPEALS OFFICE      City/State:  TROY, NY 12345
      Street 2:   1099 THIRD AVE, SUITE 301      Phone:  436-1923
      Street 3:                                    Fax:  436-5464

                      Inquiry Office Information
         Street:  2345 CENTRAL AVENUE       City/State:  ALBANY, NY 12345
      Street 2:   FREAR BUILDING                 Phone:  456-1923
      Street 3:                                    Fax:  848-5336

  Remarks

  Synonyms

          Enter ?? for more actions                                      >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

Third Party Joint Inquiry

EXAMPLE, cont.

```
Patient Policy Information    May 31, 1995 @10:07:11       Page:     1 of    3
Extended Policy Information for:   JONES,ANDREW   000-000-9281        Primary
HEALTH INS LIMITED Insurance Company                ** Plan Currently Active **

      Plan Information                          Insurance Company
  Is Group Plan:  YES                          Company:  HEALTH INS LIMITED
     Group Name:                                Street:  2345 CENTRAL AVENUE
   Group Number:  GN 48923222                 Street 2:  FREAR BUILDING
   Type of Plan:                              Street 3:
                                            City/State:  ALBANY, NY 12345

    Utilization Review Info                Effective Dates & Source
          Require UR:                     Effective Date:  01/01/87
    Require Pre-Cert:                    Expiration Date:
    Exclude Pre-Cond:                     Source of Info:  INTERVIEW
 Benefits Assignable:  YES

     Subscriber Information          Subscriber's Employer Information
   Whose Insurance:  VETERAN   Claims to Employer:  No, Send to Insurance
   Subscriber Name:  JONES,ANDREW         Company:
      Relationship:  PATIENT                Street:
  Insurance Number:  9849333             City/State:
  Coord.  Benefits:  PRIMARY                  Phone:

        User Information                Insurance Contact (last)
       Entered By:  SMITH,ALICE       Person Contacted:
       Entered On:  09/07/93         Method of Contact:
  Last Verified By:  SMITH,ALICE       Contact's Phone:
  Last Verified On:  01/03/95             Contact Date:
   Last Updated By:  BROWN,NANCY
   Last Updated On:  04/06/94

 Comment -- Patient Policy
 None

 Comment -- Group Plan

 Personal Riders
    Rider #1:     EXTEND COVERAGE TO 365 DAYS
    Rider #2:     AMBULANCE COVERAGE

+         Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

EXAMPLE, cont.

```
Annual Benefits                May 17, 1996 15:39:23          Page:    1 of    3
Annual Benefits for: GHI Ins. Co                                          Primary
             Policy: GN 48923222               Ben Yr:  MAR 01, 1993
```

Policy Information

Max. Out of Pocket: $ 500
Ambulance Coverage (%): 85 %

Inpatient

Annual Deductible:	$ 500	Drug/Alcohol Lifet. Max:	$
Per Admis. Deductible:	$ 100	Drug/Alcohol Annual Max:	$
Inpt. Lifetime Max:	$	Nursing Home (%):	
Inpt. Annual Max:	$	Other Inpt. Charges (%):	
Room & Board (%):			

Outpatient

Annual Deductible:	$ 50	Surgery (%):	
Per Visit Deductible:	$ 50	Emergency (%):	85%
Lifetime Max:	$	Prescription (%):	80%
Annual Max:	$	Adult Day Health Care?:	UNK
Visit (%):		Dental Cov. Type:	PERCENTAGE AMOU
Max Visits Per Year:		Dental Cov. (%):	48%

Mental Health Inpatient

MH Inpt. Max Days/Year:	
MH Lifetime Inpt. Max:	$
MH Annual Inpt. Max:	$
Mental Health Inpt. (%):	

Mental Health Outpatient

MH Opt. Max Days/Year:	
MH Lifetime Opt. Max:	$
MH Annual Opt. Max:	$
Mental Health Opt. (%):	

Home Health Care

Care Level:	
Visits Per Year:	
Max. Days Per Year:	
Med. Equipment (%):	
Visit Definition:	

Hospice

Annual Deductible:	$
Inpatient Annual Max.:	$
Lifetime Max.:	$
Room and Board (%):	
Other Inpt. Charges (%):	

Rehabilitation

OT Visits/Yr:	
PT Visits/Yr:	
ST Visits/Yr:	
Med Cnslg. Visits/Yr:	

IV Management

IV Infusion Opt?:	UNK
IV Infusion Inpt?:	UNK
IV Antibiotics Opt?:	UNK
IV Antibiotics Inpt?:	UNK

User Information

Entered By: BROWN,NANCY
Entered On: 02/02/94
Last Updated By: BROWN,NANCY
Last Updated On: 02/18/94

```
          Enter ?? for more actions                                        >>>
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EL  Patient Eligibility
                          AL  Go to Active List     EX  Exit Action
Select Action: Quit//
```

EXAMPLE, cont.

```
Patient Eligibility          May 20, 1996 07:45:44          Page:    1 of    1
N10273   JONES,ANDREW  A9281            DOB: 07/07/50   Subsc ID:

            Means Test: CATEGORY A                        Insured: Yes
           Date of Test: 08/24/94                    A/O Exposure:
  Co-pay Exemption Test:                            Rad. Exposure:
           Date of Test:

     Primary Elig. Code: NSC
    Other Elig. Code(s): EMPLOYEE
                         AID & ATTENDANCE
       Service Connected: No
     Rated Disabilities: BONE DISEASE (0%-NSC)
                         DEGENERATIVE ARTHRITIS (40%-NSC)


          Enter ?? for more actions
BC  Bill Charges          AR  Account Profile       VI  Insurance Company
DX  Bill Diagnosis        CM  Comment History       VP  Policy
PR  Bill Procedures       IR  Insurance Reviews     AB  Annual Benefits
CI  Go to Claim Screen    HS  Health Summary        EX  Exit Action
                          AL  Go to Active List
Select Action: Quit//
```

CHAMPUS Billing Menu
Delete Reject Entry

New Option

Introduction

This option allows you to delete individual entries from the CHAMPUS PHARMACY REJECTS (#351.52) file. Entries are automatically deleted from this file when a rejected transmission is re-submitted and subsequently approved. However, there will be instances when rejected transmissions will not be re-submitted. Therefore, this option may be used to purge unwanted reject transactions from the file.

Example

```
Enter the RX# of the rejected transmission: 100136

Prescription: 100136
     Patient: MINARDI,JOHN

The original fill for this prescription has been rejected.
Is it okay to delete this reject entry? YES
The reject entry has been deleted.
```

CHAMPUS Billing Menu
Reject Report

New Option

Introduction

The Reject Report allows you to view all of the entries in the CHAMPUS PHARMACY REJECTS (#351.52) file and determine the reason(s) for the rejected entries. Rejected entries for transactions which will not be re-submitted and continue to be displayed on this report may be deleted using the Delete Reject Entry option.

Example

```
================================================================================
Date: 05/30/97            IPS Unresolved Reject Report                Page:  1
================================================================================

RX# 100136, filled on 09/10/96 (MINARDI,JOHN 434534531) rejected because:
    Invalid NDC Number
    Missing/Invalid Insurance data
    NDC not in local AWP file
    Call Failed

RX# 100114, filled on 02/03/94 (SMITH,MARY-JO E 524051064P) rejected because:
    Modem is not Responding
    Bad/Invalid baud Rate Setting
    Call Interrupted by User
    Bad/Invalid Data bits Setting
```

CHAMPUS Billing Menu
Resubmit a Claim

New Option

Introduction

This option is used to re-submit a transaction which was originally rejected by the FI (Fiscal Intermediary - the company with which a Tricare patient holds their Tricare insurance coverage). The user is allowed to select a prescription which has not been submitted for billing, or was submitted and then rejected. The prescription is then placed in the queue to be processed by the IB background filer, and it is processed in the same manner as prescriptions which are queued by the foreground processor. If the prescription was previously submitted and rejected, the reject entry in file #351.52 will automatically be deleted if the prescription is authorized for billing.

Example

```
Enter the RX# you wish to resubmit: 100136

Prescription: 100136
     Patient: MINARDI,JOHN

The original fill for this prescription can be billed.
Is it okay to bill this prescription? YES
Outpatient Pharmacy software - Version 6.0

Division: ALBANY ISC

          You are logged on under the ALBANY ISC division.

Select LABEL PRINTER: A400-10/6/UP  HP IIIsi RIGHT MARGIN: 80// <RET>

OK TO ASSUME LABEL ALIGNMENT IS CORRECT ? YES//<RET>
The prescription has been submitted for billing.
```

CHAMPUS Billing Menu
Reverse a Claim

New Option

Introduction

This option may be used to reverse or cancel a claim for a prescription that was submitted in error. The user is allowed to select a prescription which was previously billed. The prescription is then placed in the queue to be processed by the IB background filer. The filer creates a cancellation-type transaction message which is transmitted to the RNA package. When the receipt confirmation has been received by VISTA from the Fiscal Intermediary (FI), through RNA, another job is queued which cancels the patient copayment charge and the claim for the FI.

Example

```
Enter the RX# you wish to reverse: 100136

Prescription: 100136
     Patient: MINARDI,JOHN
 The claim for the original fill for this prescription was rejected.

Enter the RX# you wish to reverse: 100114

Prescription: 100114
     Patient: SMITH,MARY-JO E

More than one fill for rx# 100114 may be canceled.

     Select one of the following:

          0         Original Fill (filled 01/04/94)
          1         Refill #1 (filled 02/03/94)

Select one of the fills by number: 1  Refill #1 (filled 02/03/94)
Is it okay to cancel this prescription? YES
The claim reversal has been submitted.
```

CHAMPUS Billing Menu
Transmission Report

New Option

Introduction

The Transmission report allows you to view a list of pharmacy transmissions for prescriptions which were filled during a specified date range.

Example

```
================================================================================
Date: 05/30/97          IPS Prescription Status Report                Page: 1
                      JAN 1,1996 through MAY 30,1997
RX#             Fill Date   Patient Name                        Patient SSN
NDC             AWP       Copay     Ing Cost  Fee Paid  Total PD
                Auth. #                Message
Reject Failure Codes
================================================================================


100136          09/10/96    MINARDI,INS                         434534531
  Drug Name: PRESAMINE 50MG TABS
     Status: Rejected
    Invalid NDC Number
    Missing/Invalid Insurance data
    NDC not in local AWP file
    Call Failed
```